MEDI-CAL
MAY 2007
LOCAL ASSISTANCE ESTIMATE
for
FISCAL YEARS
2006-07 and 2007-08

REGULAR POLICY CHANGES

Fiscal Forecasting and Data Management Branch
State Department of Health Services
1501 Capitol Avenue
Sacramento, CA 95814
(916) 552-8550
www.dhs.ca.gov/ffdmb

MEDI-CAL PROGRAM REGULAR POLICY CHANGE INDEX

MEDI-CAL PROGRAM REGULAR
POLICY CHANGE INDEX

MEDI-CAL PROGRAM REGULAR
POLICY CHANGE INDEX

POLICY CHANGE NUMBER	POLICY CHANGE TITLE
	HOSPITAL FINANCING
79	HOSP FINANCING - CCS AND GHPP
80	HOSP FINANCING - DISTRESSED HOSPITAL FUND
81	HOSP FINANCING - DPH INTERIM RATE GROWTH
82	HOSP FINANCING - NDPH SUPPLEMENTAL PMT
83	HOSP FINANCING - HEALTH CARE COVERAGE
84	HOSP FINANCING - DPH INTERIM RECONCILIATION
85	HOSP FINANCING - STABILIZATION FUNDING
86	HOSP FINANCING - BCCTP
87	BASE ADJUSTMENT - DPH INTERIM RATE
88	HOSP FINANCING - MIA LTC
89	HOSP FINANCING - DPH RATE RECONCILIATION
	SUPPLEMENTAL PMNTS.
90	CAPITAL PROJECT DEBT REIMBURSEMENT
91	HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENT
92	IGT FOR NON-SB 1100 HOSPITALS
93	FFP FOR LOCAL TRAUMA CENTERS
94	CERTIFICATION PAYMENTS FOR DP-NFS
95	DSH OUTPATIENT PAYMENT METHOD CHANGE
96	SRH OUTPATIENT PAYMENT METHOD CHANGE
97	DSH PAYMENTS
98	FREESTANDING CLINICS & VETERANS' HOMES SUPPL.
	OTHER
110	HEALTHY FAMILIES - CDMH
111	NURSE-TO-PATIENT RATIOS FOR HOSPITALS
114	MINOR CONSENT SETTLEMENT
118	TWO-PLAN MODEL NOTICES OF DISPUTE
120	ESTATE RECOVERY REGULATIONS
121	FFP REPAYMENT-SPECIALTY MENTAL HEALTH
122	CIGARETTE AND TOBACCO SURTAX FUNDS
124	INDIAN HEALTH SERVICES
125	ANTI-FRAUD EXPANSION FOR FY 2004-05
126	NON-INSTITUTIONAL PROVIDER OVERPAYMENTS
127	STATE-ONLY IMD ANCILLARY SERVICES
128	ANTI-FRAUD EXPANSION FOR FY 2007-08
129	MEDICAL SUPPORT ENHANCEMENTS
130	GLAXOSMITHKLINE SETTLEMENT
131	EDS COST CONTAINMENT PROJECTS

MEDI-CAL PROGRAM REGULAR
POLICY CHANGE INDEX

FAMILY PLANNING INITIATIVE

REGULAR POLICY CHANGE NUMBER: 1
IMPLEMENTATION DATE: 1/1997
ANALYST: Betty Lai
FISCAL REFERENCE NUMBER: 1

	FY 2006-07	FY 2007-08
FULL YEAR COST - TOTAL FUNDS	$438,372,000	$451,046,000
- STATE FUNDS	$133,048,400	$136,895,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$438,372,000	$451,046,000
STATE FUNDS	$133,048,400	$136,895,000
FEDERAL FUNDS	$305,323,600	$314,151,000

DESCRIPTION

Effective January 1, 1997, family planning services were expanded under the Family PACT program to provide contraceptive services to more persons in need of such services who have incomes under 200% of poverty.

A Section 1115 demonstration project waiver was approved by CMS effective December 1, 1999. Family planning services and testing for sexually transmitted infections (STIs) (about 84% of FPACT costs) are eligible for 90% FFP; treatment of STIs and other family planning companion services (about 15% of costs) are eligible for the Title XIX FMAP; and treatment of other medical conditions, including inpatient care for complications from family planning services (about 1% of costs) are not eligible for FFP. Within these categories, costs for undocumented persons (assumed to be 17.79% of the Family PACT population) are budgeted at 100% GF.

The original waiver expired on November 30, 2004. On May 27, 2004, the Department submitted an application for a three-year renewal. The renewal request is being evaluated by CMS. Extensions are being granted in one-month increments.

Drug rebates for Family PACT drugs are included in the Family PACT Drug Rebate Program policy change.

FAMILY PLANNING INITIATIVE

REGULAR POLICY CHANGE NUMBER: 1

Estimate by Service Category:

	FY 2006-07		FY 2007-08	
Service Category	**TF**	**GF**	**TF**	**GF**
Physicians	$50,608,000	$15,360,000	$50,153,000	$15,222,000
Other Medical	$260,183,000	$78,967,000	$268,343,000	$81,444,000
County Outpatient	$3,949,000	$1,199,000	$4,164,000	$1,264,000
Community Outpatient	$4,630,000	$1,405,000	$4,689,000	$1,423,000
Pharmacy	$119,002,000	$36,118,000	$123,697,000	$37,543,000
TOTAL	**$438,372,000**	**$133,049,000**	**$451,046,000**	**$136,896,000**

BREAST AND CERVICAL CANCER TREATMENT

REGULAR POLICY CHANGE NUMBER:	2
IMPLEMENTATION DATE:	1/2002
ANALYST:	Betty Lai
FISCAL REFERENCE NUMBER:	3

	FY 2006-07	FY 2007-08
FULL YEAR COST - TOTAL FUNDS	$93,117,000	$106,430,000
- STATE FUNDS	$41,199,550	$48,328,450
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$93,117,000	$106,430,000
STATE FUNDS	$41,199,550	$48,328,450
FEDERAL FUNDS	$51,917,450	$58,101,550

DESCRIPTION

The Budget Act of 2001 (Ch. 106/2001) authorized the Breast and Cervical Cancer Treatment Program (BCCTP) effective January 1, 2002, for women under 200% of the FPL.

Enhanced Title XIX Medicaid funds (65%FFP/35%GF) may be claimed under the federal Medicaid Breast and Cervical Cancer Treatment Act of 2000 (P.L. 106-354) for cancer treatment and full scope Medi-Cal benefits for women under age 65 who are citizens or legal immigrants with no other health coverage.

A State-Only program covers women aged 65 or older, women with inadequate health coverage, undocumented women, and males for cancer treatment only. The coverage term is 18 months for breast cancer and 2 years for cervical cancer. Estimated State-Only costs include undocumented persons' nonemergency services during cancer treatment.

Beneficiaries are screened through Centers for Disease Control (CDC) and Family PACT providers.

Assumptions:

1. There were 10,338 fee-for-service (FFS) eligibles and 1,490 managed care eligibles as of January 2007 (total of 11,828). 3,377 of the FFS eligibles were eligible for State-Only services (Aid Codes 0R, 0T, 0U and 0V).

2. 954 of the FFS eligibles were in Accelerated Enrollment Aid Code 0N as of January 2007.

3. 331 of the FFS eligibles were in State-Only Other Health Coverage Aid Code 0R as of January 2007. Assume the State will pay Medicare and other health coverage premiums for an average of 337 0R beneficiaries monthly in FY 2006-07 and 622 OR beneficiaries monthly in FY 2007-08. Assume an average monthly premium cost per beneficiary of $200.

   FY 2006-07: 337 x $200 x 12 months = $ 809,000 ($809,000 GF)
   FY 2007-08: 622 x $200 x 12 months = $1,493,000 ($1,493,000 GF)

BREAST AND CERVICAL CANCER TREATMENT

REGULAR POLICY CHANGE NUMBER: 2

4. FFS costs are estimated as follows:

	FY 2006-07		FY 2007-08	
	TF	**GF**	**TF**	**GF**
Full-Scope Costs	$79,873,000	$27,955,000	$89,387,000	$31,285,000
State-Only Costs				
Services	$12,435,000	$12,435,000	$15,550,000	$15,550,000
Premiums	$809,000	$809,000	$1,493,000	$1,493,000
Total	**$93,117,000**	**$41,199,000**	**$106,430,000**	**$48,328,000**

5. All BCCTP costs are budgeted in policy changes. BCCTP managed care costs are budgeted in managed care policy changes.

6. Federal reimbursement for a portion of State-Only BCCTP costs based on the certification of public expenditures is budgeted in the Policy Change Hosp. Financing - BCCTP.

REDETERMINATION FORM SIMPLIFICATION

REGULAR POLICY CHANGE NUMBER:	3
IMPLEMENTATION DATE:	5/2006
ANALYST:	Stella Bertrand
FISCAL REFERENCE NUMBER:	1066

	FY 2006-07	FY 2007-08
FULL YEAR COST - TOTAL FUNDS	$46,823,000	$77,120,000
- STATE FUNDS	$23,411,500	$38,560,000
PAYMENT LAG	0.8140	1.0000
% REFLECTED IN BASE	93.29 %	100.00 %
APPLIED TO BASE		
TOTAL FUNDS	$2,557,400	$0
STATE FUNDS	$1,278,720	$0
FEDERAL FUNDS	$1,278,720	$0

DESCRIPTION

The Medi-Cal annual redetermination form (MC 210 RV) has been revised to make it more user friendly, shorter, and easier for beneficiaries to complete. As a result of the changes, more beneficiaries who would have otherwise not completed the form and, therefore, would no longer be eligible, will now complete the annual redetermination process (RV) and maintain coverage.

Assumptions:

1. Using data input from 7 CWDs, with a combined 65.2% of the statewide Medi-Cal caseload, assume that the percentage of RV approved per month is 3% of the number of beneficiaries.

2. Based on point-in-time data from October 2005 through September 2006, the average Medi-Cal only monthly beneficiaries statewide is 3,652,556, excluding long-term care. The monthly number subject to RVs is:

   3,652,556 x 3% = 109,577

3. Assume that 2% more of the beneficiaries will complete the RV.

   109,577 x 2% = 2,192

4. Assume that the cost of benefits is the November 2006 Estimate current year average cost per beneficiaries for each aid category. This results in a weighted average of benefits and dental costs per beneficiary in the impacted aid categories of $209.42.

5. The monthly cost of benefits for the additional beneficiaries who complete the redetermination process will be:

   2,192 x $209.42 = $459,049

REDETERMINATION FORM SIMPLIFICATION

REGULAR POLICY CHANGE NUMBER: 3

6. Assume that the use of the revised form will have its first impact on the number of beneficiaries in the month of May 2006. The monthly rate of increase due to the use of the form will phase-in through FY 2006-07.

$459,049 x 2 months from FY 2005-06 x 12 months =	$11,017,000	
$459,049 x 78 (12, 11, 10…) =	$35,806,000	
FY 2006-07 cost of benefits	**$46,823,000**	**($23,411,500 GF)**
$459,049 x 14 months growth X 12 months =	$77,120,000	
FY 2007-08 cost of benefits (rounded)	**$77,120,000**	**($38,560,000 GF)**

7. Average monthly eligibles that are added due to the redetermination form simplification are 18,632 in FY 2006-07 (93.29% in base) and 30,688 in FY 2007-08 (100% in base).

CHDP GATEWAY - PREENROLLMENT

REGULAR POLICY CHANGE NUMBER:	4
IMPLEMENTATION DATE:	7/2003
ANALYST:	Betty Lai
FISCAL REFERENCE NUMBER:	8

	FY 2006-07	FY 2007-08
FULL YEAR COST - TOTAL FUNDS	$18,285,000	$18,285,000
- STATE FUNDS	$6,399,750	$6,399,750
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$18,285,000	$18,285,000
STATE FUNDS	$6,399,750	$6,399,750
FEDERAL FUNDS	$11,885,250	$11,885,250

DESCRIPTION

The CHDP Gateway program was implemented July 1, 2003. Children who receive a CHDP screen are preenrolled (PE) in Medi-Cal or the Healthy Families Program (HFP). PE provides a minimum of 2 months of full-scope coverage, during which the family may apply for ongoing Medi-Cal or HFP coverage. The state-funded CHDP program continues to provide screens to children eligible for limited-scope Medi-Cal.

Assumptions:

1. In CY 2006, 652,047 children were screened through the Gateway. Medi-Cal: 529,867 (81%), HFP: 79,537 (12%), CHDP State-Only 42,643 (7%).

2. CY 2006 average monthly Medi-Cal or HFP PE eligibles and annual costs were as follows:

Medi-Cal PE	88,305	$118,770,000	($59,385,000 SF) **
HFP PE	13,239	$18,285,000	($6,399,750 GF)
Total	101,544	$137,055,000	($65,784,750 SF)

3. CHDP State-Only costs are budgeted in the Family Health Estimate.

4. It is assumed that the average monthly eligibles/annual costs will be similar for FY 2006-07 and FY 2007-08.

5. All costs for Medi-Cal Gateway PE are 100% in the base. Costs for HFP Gateway PE eligibles are not included in the base, and are shown here:

FY 2006-07: HFP: **$18,285,000** ($6,399,750 GF)
FY 2007-08: HFP: **$18,285,000** ($6,399,750 GF)

CHDP GATEWAY - PREENROLLMENT

REGULAR POLICY CHANGE NUMBER: 4

6. The federal funds for both Medi-Cal and HFP Gateway PE costs are budgeted in Title XXI, Item 4260-113 funding.

7. Based on information provided by the Children's Medical Services Branch, assume that $130,000 SF in both FY 2006-07 and FY 2007-08 will be Childhood Lead Poisoning Prevention (CLPP) funding.

** $130,000 SF CLPP

BRIDGE TO HFP

REGULAR POLICY CHANGE NUMBER:	5
IMPLEMENTATION DATE:	11/1998
ANALYST:	Stella Bertrand
FISCAL REFERENCE NUMBER:	5

	FY 2006-07	FY 2007-08
FULL YEAR COST - TOTAL FUNDS	$9,226,000	$9,613,000
- STATE FUNDS	$3,229,100	$3,364,550
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$9,226,000	$9,613,000
STATE FUNDS	$3,229,100	$3,364,550
FEDERAL FUNDS	$5,996,900	$6,248,450

DESCRIPTION

In order to allow time to apply for Healthy Families, AB 2780 (Chapter 310, Statutes of 1998) provides one month additional Medi-Cal eligibility as a bridge for children who become ineligible for Medi-Cal or begin to have a share-of-cost and have income between 100% and 200% of poverty.

Assumptions:

1. Based on current Medi-Cal data, the average monthly number of beneficiaries in FY 2006-07 will be 6,914.

2. Continuing the trend, there will be an average of 7,204 beneficiaries per month for the first half of FY 2007-08.

3. Based on cost data from August 2005 through January 2007, assume the cost of benefits is $74.18 per month for fee-for-service children in July 2006, and $74.17 from August 2006 through June 2008. For children in managed care plans, costs are estimated to be $136.12 in July 2006 and $136.11 from August 2006 through June 2008.

4. There are 33,370 fee-for-service eligible-months in FY 2006-07 (2,781 for July 2006 and 30,589 for August 2006 through June 2007) and 34,770 in FY 2007-08.

5. There are 49,598 managed care eligible-months in FY 2006-07 (4,133 for July 2006 and 45,465 for August 2006 through June 2008) and 51,679 in FY 2007-08.

BRIDGE TO HFP

REGULAR POLICY CHANGE NUMBER: 5

FY 2006-07:	FFS	2,781 x $74.18 per mo.	= $206,000
		30,589 x $74.17 per mo.	= $2,269,000
	Total FFS		**= 2,475,000**
	Mgd Care	4,133 x $136.12 per mo.	= $563,000
		45,465 x $136.11 per mo.	= $6,188,000
	Total Managed Care		**= 6,751,000**
	FY 2006-07 Total		**= $9,226,000**
FY 2007-08:	FFS	34,770 x $74.17 per mo.	= $2,579,000
	Mgd Care	51,679 x $136.11 per mo.	= $7,034,000
		Total	**= $9,613,000**

6. This is a Title XXI program with enhanced FFP of 65.00% in FY 2006-07 and FY 2007-08. These costs are budgeted in 4260-113-0001/0890.

FY 2006-07	**$9,226,000 x 65.00%**	**= $5,996,900 FFP**
FY 2007-08	**$9,613,000 x 65.00%**	**= $6,248,500 FFP**

7. The one-month Bridge to HFP may be replaced by the HFP Presumptive Eligibility program under SB 437 after completion of the internal FSR and needed system changes.

SHIFT OF CCS STATE/COUNTY COSTS TO MEDI-CAL

REGULAR POLICY CHANGE NUMBER:	6
IMPLEMENTATION DATE:	4/2006
ANALYST:	Betty Lai
FISCAL REFERENCE NUMBER:	1117

	FY 2006-07	FY 2007-08
FULL YEAR COST - TOTAL FUNDS	$5,000,000	$5,000,000
- STATE FUNDS	$2,500,000	$2,500,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$5,000,000	$5,000,000
STATE FUNDS	$2,500,000	$2,500,000
FEDERAL FUNDS	$2,500,000	$2,500,000

DESCRIPTION

On April 4, 2006, the Medi-Cal/California Children Services fiscal intermediary contractor EDS installed an erroneous payment correction (EPC) in the claims payment system. Claims for CCS-only children later determined to be retroactively eligible for Medi-Cal, or for CCS/Medi-Cal children with a Medi-Cal share of cost, were identified and reprocessed. This reprocessing results in a shift of costs for claims which had previously been paid from State General Fund/County CCS-only funds to Medi-Cal funds. EPCs are expected to be completed twice each year.

Assumptions:

1. Based on data provided by the Children's Medical Services Branch, the estimated shift is expected to be $5,000,000 in each of FY 2006-07 and FY 2007-08.

2. These costs are currently funded with GF and county funds of $2,500,000 each in the current and budget years, and may have been eligible for funding under the Medi-Cal Hospital/Uninsured Care Demonstration Waiver Safety Net Care Pool.

3. The total cost to Medi-Cal is estimated to be $5,000,000 ($2,500,000 GF, $2,500,000 FFP) in the current and budget years.

ELIG. FOR CHILDREN IN MONTH PRIOR TO SSI/SSP GRANT

REGULAR POLICY CHANGE NUMBER:	7
IMPLEMENTATION DATE:	2/2007
ANALYST:	Stella Bertrand
FISCAL REFERENCE NUMBER:	1110

	FY 2006-07	FY 2007-08
FULL YEAR COST - TOTAL FUNDS	$2,061,000	$4,945,000
- STATE FUNDS	$1,030,500	$2,472,500
PAYMENT LAG	0.7330	0.9870
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,510,700	$4,880,700
STATE FUNDS	$755,360	$2,440,360
FEDERAL FUNDS	$755,360	$2,440,360

DESCRIPTION

Currently automatic eligibility for Medi-Cal is provided to Supplemental Security Income/State Supplementary Payment (SSI/SSP) program recipients in the month in which they receive their first SSI/SSP check. This is the month following the month of application for SSI/SSP or the month, in which their SSI/SSP eligibility is established, whichever is later. This eligibility is established systematically on the Medi-Cal Eligibility Data System (MEDS), based on information that comes from the Social Security Administration (SSA) through monthly computer files.

The Deficit Reduction Act (DRA) of 2005 creates a mandatory program for disabled individuals under 21 years of age who are determined to be eligible for SSI/SSP and receive their first check in the following month. The DRA provides these individuals with Medicaid eligibility in the month prior to the first month in which they receive a grant. CMS has given the Department approval to establish this eligibility systematically based upon the dates included in the monthly computer data files received from SSA. This mandatory coverage was effective with the February 2007 month of eligibility.

Assumptions:

1. Based on data from January 2004 through August 2005, an average of 938 persons per month under the age of 21 become SSI/SSP eligible each month who did not request Medi-Cal coverage for the three months prior to the month of application. Those that do request retroactive coverage already have Medi-Cal coverage for the month before the SSI grant began.

2. 790 of the 938 are age one or older. It is assumed that those that are under age one are covered under their mothers' cards prior to SSI/SSP eligibility or request three-month retroactive coverage, so they are already covered for the month before the SSI/SSP grant begins.

3. Assume the cost of service in the month prior to the month in which the SSI/SSP grant begins is limited to outpatient and dental costs since these children can already get coverage for this month by applying for retroactive coverage. It is assumed they would have applied for this coverage if they had inpatient costs.

ELIG. FOR CHILDREN IN MONTH PRIOR TO SSI/SSP GRANT

REGULAR POLICY CHANGE NUMBER: 7

4. Based on costs for public assistance and medically needy disabled and blind Medi-Cal beneficiaries under 21 for dates of service in 2005, the average cost per month for outpatient services paid through EDS is $513.17. The current capitation rate for dental services is $8.51.

   $513.17 + $8.51 = $521.68 monthly outpatient costs

   FY 2006-07:
   790 children x $521.68 cost a month x 5 months = **$2,061,000 ($1,030,500 GF)**

   FY 2007-08 and annual cost:
   790 children x $521.68 cost a month x 12 months = **$4,945,000 ($2,472,500 GF)**

MEDI-CAL/HF BRIDGE PERFORMANCE STANDARDS

REGULAR POLICY CHANGE NUMBER: 8
IMPLEMENTATION DATE: 1/2007
ANALYST: Stella Bertrand
FISCAL REFERENCE NUMBER: 1010

	FY 2006-07	FY 2007-08
FULL YEAR COST - TOTAL FUNDS	$1,359,000	$2,718,000
- STATE FUNDS	$475,650	$951,300
PAYMENT LAG	0.6390	0.9840
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$868,400	$2,674,500
STATE FUNDS	$303,940	$936,080
FEDERAL FUNDS	$564,460	$1,738,430

DESCRIPTION

To ensure that all children who are discontinued from Medi-Cal due to increased income have the opportunity to apply for the Healthy Families Program, the Department implemented county performance standards for compliance with the Medi-Cal Bridge to Healthy Families Program (aid code 7X), effective January 2007.

Assumptions:

1. Currently, an estimated 82,971 children are expected to receive the one-month bridge to the Healthy Families Program in 2006-07.

2. Implementation of performance standards is expected to increase the number of children receiving the bridge by 34,000 annually.

3. Assuming a January 2007 implementation, there will be an increase of 17,000 beneficiaries in 2006-07.

4. Based on fee-for-service cost data and managed care capitation rates for beneficiaries in aid code 7X, the average cost per aid code 7X beneficiary is $79.93.

   FY 2006-07: 17,000 x $79.93 = **$1,359,000 ($475,700 GF)**

   Annual cost: 34,000 x $79.93 = **$2,718,000 ($951,300 GF)**

   **Funding is from Title XXI SCHIP funds (4260-113) at 65% FFP/35% GF.

BCCTP RETROACTIVE COVERAGE

REGULAR POLICY CHANGE NUMBER:	10
IMPLEMENTATION DATE:	1/2007
ANALYST:	Betty Lai
FISCAL REFERENCE NUMBER:	1030

	FY 2006-07	FY 2007-08
FULL YEAR COST - TOTAL FUNDS	$401,000	$802,000
- STATE FUNDS	$140,350	$280,700
PAYMENT LAG	0.6390	0.9840
% REFLECTED IN BASE	23.07 %	12.06 %
APPLIED TO BASE		
TOTAL FUNDS	$197,100	$694,000
STATE FUNDS	$68,990	$242,900
FEDERAL FUNDS	$128,130	$451,100

DESCRIPTION

The Budget Act of 2001 (Ch. 106/2001) authorized the Breast and Cervical Cancer Treatment Program (BCCTP) effective January 1, 2002, for women under 200% of the FPL.

Title XIX Medicaid funds (65%FFP/35%GF) may be claimed under the federal Medicaid Breast and Cervical Cancer Treatment Act of 2000 (P.L. 106-354) for cancer treatment and full scope Medi-Cal benefits for women under age 65 who are citizens or legal immigrants with no other health coverage.

Due to the receipt of additional staffing, the Department has begun to process requests for the three months of retroactive BCCTP coverage prior to application for BCCTP, available under federal law for persons who met federal eligibility requirements in the months for which retroactive coverage is requested.

Assumptions:

1. In FY 2005-06, approximately 250 beneficiaries requested and qualified for 3 months of retroactive coverage. The breast/cervical cancer ratio is assumed to be 65%/35% (163/87), based on actual historical BCCTP counts.
2. Based on actual early-in-treatment claims in CY 2004, the average cost per beneficiary for retroactive coverage is estimated to be: $1,942 for breast cancer and $965 for cervical cancer.
3. Costs in FY 2005-06 are estimated to be:

   (163 claims x $1,942) + (87 claims x $965) = $401,000 ($140,000 GF).

   The FY 2005-06 costs are 100% in the base.

BCCTP RETROACTIVE COVERAGE

REGULAR POLICY CHANGE NUMBER: 10

4. Beginning January 2007, new applicants are being notified of the availability of retroactive coverage. Preliminary January 2007 data indicates that of the 300 new applicants per month about 6% are given retroactive coverage.

   300 new applicants per month X 6% = 18 new applicants per month
   18 new applicants per month X 12 months = 216 per year minimum

5. Assume the number of women requesting retroactive coverage well be at least 250 and that costs per claim in FY 2006-07 will be similar to FY 2005-06.

6. In August 2007, notices will be sent to all past BCCTP enrollees after the Internet based application is revised to include a question on retroactive coverage. Once past BCCTP enrollees are notified, assume an additional 250 enrollees will be eligible for retroactive coverage, doubling the cost in FY 2007-08.

   FY 2007-08: $401,000 X 2 = $802,000

SB 437 - SELF-CERTIFICATION

REGULAR POLICY CHANGE NUMBER:	11
IMPLEMENTATION DATE:	7/2007
ANALYST:	Stella Bertrand
FISCAL REFERENCE NUMBER:	1146

	FY 2006-07	FY 2007-08
FULL YEAR COST - TOTAL FUNDS	$0	$31,041,000
- STATE FUNDS	$0	$15,520,500
PAYMENT LAG	1.0000	0.7690
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$23,870,500
STATE FUNDS	$0	$11,935,260
FEDERAL FUNDS	$0	$11,935,260

DESCRIPTION

SB 437 (Chapter 328, Statutes of 2006) establishes a process that allows applicants and beneficiaries to self-certify the amount and nature of assets and income without the need to submit income or asset documentation. The first phase will be a pilot program to be implemented in two counties equaling 10% of the Medi-Cal population in July 2007. The second phase will implement statewide in July 2009, provided the evaluation of the pilot shows that the pilot increased enrollment and protected the integrity of the program, and the Legislature appropriates funding for the expansion.

Assumptions:

1. Self-certification applies to Medically Needy Families, Medically Indigent Children, 185% Poverty, 133% Poverty, 100% Poverty, including undocumented eligibles.

2. Based on the projected number of eligibles in these categories, the average monthly number of beneficiaries projected is 3,636,633 in FY 2007-08.

3. Assume that the number of families that will apply and become eligible solely because of self-certification will be 10 percent of the projected eligibles for FY 2007-08. No approvals are assumed in July 2007 which is the first month of implementation.

4. The rate of eligibles added due to self-certification is based on phasing in 1/12 of the total projected eligibles each month over a period of 12 months. No approvals are assumed in July 2007.

SB 437 - SELF-CERTIFICATION

REGULAR POLICY CHANGE NUMBER: 11

Month	Projected MC Family Eligibles	Pilot – 10% of Eligibles	Rate of New Eligibles	New Eligible Months
Jul-07	3,620,549	362,055	0%	
Aug-07	3,634,506	363,451	8%	3,029
Sep-07	3,643,473	364,347	17%	6,073
Oct-07	3,641,787	364,179	25%	9,105
Nov-07	3,619,689	361,969	33%	12,066
Dec-07	3,618,367	361,837	42%	15,077
Jan-08	3,633,759	363,376	50%	18,169
Feb-08	3,632,234	363,223	58%	21,188
Mar-08	3,643,579	364,358	67%	24,291
Apr-08	3,647,887	364,789	75%	27,359
May-08	3,651,882	365,188	83%	30,432
Jun-08	3,651,887	365,189	92%	33,476
Total of 2007-08 eligible months				**200,265**
Average monthly eligibles				**16,689**

5. Assume the new beneficiaries would have similar medical costs to eligibles in the MN-Family aid category.

6. Based on the November 2006 Estimate data, the average monthly cost of benefits for a person in these categories is $155.

7. Assuming a July 2007 implementation date, the estimated cost of benefits is as follows:

   2007-08 Cost of Benefits   200,265 X $155 = **$31,041,000 ($15,520,500 GF)**

HURRICANE KATRINA SECTION 1115 WAIVER

REGULAR POLICY CHANGE NUMBER: 12
IMPLEMENTATION DATE: 7/2006
ANALYST: Stella Bertrand
FISCAL REFERENCE NUMBER: 1112

	FY 2006-07	FY 2007-08
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	-$505,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	-$505,000	$0
FEDERAL FUNDS	$505,000	$0

DESCRIPTION

The Department is participating in a Hurricane Katrina Section 1115 Demonstration Project waiver. Under this waiver, Katrina evacuees may apply for Medi-Cal coverage between August 28, 2005 and January 31, 2006. Coverage continues for five months from the month of application. The final date of coverage is May 31, 2006. As a result of California's participation in the waiver, 100% of the Medi-Cal costs for the evacuees are paid for through the waiver.

The federal Deficit Reduction Act of 2005 appropriated funds for the Medicaid costs of the evacuees. California has received a grant award of $1,414,000 as its portion of the funds, to be used in lieu of the GF match. Payments above that amount may be made based upon cost reports that identify higher service costs. The federal match will be at the FMAP rates in the home states, which are Louisiana at 69.79%, Mississippi at 76.00%, and Alabama at 69.51%.

Assumptions:

1. Katrina eligibles consist of two groups: those receiving CalWORKs, and those receiving Medi-Cal only (identified as aid code 65).

2. Claims for Medi-Cal only beneficiaries were paid with 100% GF, and claims for CalWORKs beneficiaries were paid with 50% GF and 50% Title 19 FFP funds as follows:

FY 2006-07	Medi-Cal	CalWORKs	Total	GF	FFP
Louisiana	$427,991	$865,333	$1,293,324	$860,658	$432,666
Mississippi	$17,324	$58,817	$76,141	$46,733	$29,408
Alabama	$5,782	$12,172	$17,954	$11,868	$6,086
Total	$451,097	$936,322	$1,387,419	$919,259	$468,160

HURRICANE KATRINA SECTION 1115 WAIVER

REGULAR POLICY CHANGE NUMBER: 12

3. Katrina claims should be paid based on each Katrina eligibles' home state 2006 FMAP rates and the Grant Award.

FY 2006-07	Total	GF	FFP	Grant Award
Louisiana	$1,293,324	$0	$902,611	$390,713
Mississippi	$76,141	$0	$57,867	$18,274
Alabama	$17,954	$0	$12,479	$5,475
Total	$1,387,419	$0	$972,957	$414,462

4. This policy change reflects the difference between the California and the Katrina eligibles' home state 2006 FMAP rates, and the reimbursement to the GF from the Grant Award.

$972,957	FFP based on home state
$468,160	FFP claimed
$504,997	Additional FFP to be claimed

RESOURCE DISREGARD - % PROGRAM CHILDREN

REGULAR POLICY CHANGE NUMBER:	13
IMPLEMENTATION DATE:	12/1998
ANALYST:	Stella Bertrand
FISCAL REFERENCE NUMBER:	13

	FY 2006-07	FY 2007-08
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	-$19,480,200	-$19,480,200
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	-$19,480,200	-$19,480,200
FEDERAL FUNDS	$19,480,200	$19,480,200

DESCRIPTION

Based on the provisions of SB 903 (Chapter 624, Statutes of 1997), resources will not be counted in determining the Medi-Cal eligibility of children with family income within Percentage Program limits.

Assumptions:

1. Aid codes (8N, 8P, 8R, and 8T) that identify children eligible for Medi-Cal due to disregarding assets were implemented in December 1998.

2. In these aid codes, there were 4,895 eligibles in July 1999, 8,214 in December 1999, 16,979 in December 2000, 36,868 in December 2001, 49,293 in December 2002, 61,741 in December 2003, 87,364 in December 2004, and 89,665 in December 2005.

3. Average monthly eligibles, which are included in the base, are estimated to be 108,754 in FY 2006-07 and 108,954 in FY 2007-08.

4. Enhanced federal funding under Title XXI (MCHIP) may be claimed for children eligible under these aid codes. It is 65.00% in FY 2006-07 and will be 65.00% in FY 2007-08.

5. Beginning in FY 2000-01, these costs are being budgeted in 4260-113. Only the FFP in excess of the regular Medi-Cal FMAP is budgeted here, as the costs are included in the base.

	FY 2006-07	**FY 2007-08**
Total	$129,868,000	$129,868,000
FFP	$84,414,200	$84,414,200
General Fund	$45,453,800	$45,453,800
Enhanced FFP	**$19,480,000**	**$19,480,000**

REFUGEES

REGULAR POLICY CHANGE NUMBER:	14
IMPLEMENTATION DATE:	7/1980
ANALYST:	Ken Jansma
FISCAL REFERENCE NUMBER:	14

	FY 2006-07	FY 2007-08
FULL YEAR COST - TOTAL FUNDS	$0	$5,596,000
- STATE FUNDS	-$2,588,000	$5,596,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$5,596,000
STATE FUNDS	-$2,588,000	$5,596,000
FEDERAL FUNDS	$2,588,000	$0

DESCRIPTION

Full federal funding is available through the Refugee Resettlement Program (RRP) for refugees receiving Refugee Cash Assistance (Aid Codes 01,08, and 0A) and for Refugee Medical Assistance refugees (Aid Code 02) during their first 8 months in the United States.

In the Current Year (FY 2006-07) this policy change is a funding adjustment to shift the 50% state share of costs for refugees to federal funds to reflect the full federal funding available to the Department through the RRP federal grant. Total refugee expenditures are estimated to be $5,176,000 in FY 2006-07.

Beginning July 1, 2007, the RRP federal grant will be in the new California Department of Public Health (CDPH), which has program responsibility through the Refugee Health Assessment Program. The federal Office of Refugee Resettlement will only allow one grant award for refugee health services in the state. Therefore, starting in the Budget Year (FY 2007-08) the new California Department of Health Care Services will invoice the CDPH for reimbursement of refugee expenditures. Total refugee expenditures, which will be reimbursed by CDPH, are estimated to be $5,596,000 in FY 2007-08.

This reimbursement in FY 2007-08 is included on the 4260-610-0995 Reimbursement line in the Management Summary.

NEW QUALIFIED ALIENS

REGULAR POLICY CHANGE NUMBER:	15
IMPLEMENTATION DATE:	12/1997
ANALYST:	Stella Bertrand
FISCAL REFERENCE NUMBER:	15

	FY 2006-07	FY 2007-08
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$132,423,000	$133,165,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$132,423,000	$133,165,000
FEDERAL FUNDS	-$132,423,000	-$133,165,000

DESCRIPTION

HR 3734, the Welfare Reform Bill, specified that FFP is not available for full-scope Medi-Cal services for nonexempt qualified aliens who enter the country after August 1996, for the first 5 years they are in the country. They are eligible for FFP for emergency services only. As California law requires that legal immigrants receive the same services as citizens, the nonemergency services are only State funded. Based on actual expenditure reports for the fee-for-service (FFS) nonemergency services costs of New Qualified Aliens from January 2002 through December 2006, the remainder of the current year and the budget year were projected. Using information available on the percentage managed care expenditures are of FFS expenditures for nonemergency services in FY 2005-06 (36.91%), the managed care totals were derived.

The impact of SCHIP funding for prenatal care for new qualified aliens is included in the SCHIP Funding for Prenatal Care policy change.

		FFS	Managed Care	Total
FY 2006-07:	Jul-Sep 06	$46,287,859		
	Oct-Dec 06	$51,517,743		
	Jan-Mar 07	$49,116,482		
	Apr-Jun 07	$46,523,119		
	Totals	$193,445,203	$71,400,624	$264,846,000
	FFP Repayment			**$132,423,000**

		FFS	Managed Care	Total
FY 2007-08:	Jul-Sep 07	$44,941,844		
	Oct-Dec 07	$51,203,785		
	Jan-Mar 08	$47,880,218		
	Apr-Jun 08	$50,503,089		
	Totals	$194,528,936	$71,800,630	$266,330,000
	FFP Repayment			**$133,165,000**

ACCELERATED ENROLLMENT-SCHIP TITLE XXI

REGULAR POLICY CHANGE NUMBER:	16
IMPLEMENTATION DATE:	10/2003
ANALYST:	Betty Lai
FISCAL REFERENCE NUMBER:	199

	FY 2006-07	FY 2007-08
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$0

DESCRIPTION

Applications received by the Single Point of Entry (SPE) are screened for Medi-Cal eligibility based on income. For children who appear Medi-Cal eligible without a share of cost, the SPE establishes accelerated enrollment and inputs eligibility transactions to the MEDS database.

Effective October 1, 2003, the federal share of accelerated enrollment costs is funded from Title XXI under 4260-113. The federal sharing ratio is the regular FMAP for Title XIX.

Assumptions:

Estimated costs are based on actual claims and dental capitation rates for aid code 8E during January to December of 2006.

FY 2006-07:	$13,572,000	($6,786,000 GF)
FY 2007-08:	$13,572,000	($6,786,000 GF)

The costs of this policy change are fully reflected in the base estimate. This policy change identifies the shift in funding from Title XIX (4260-101) to Title XXI (4260-113).

ADULT DAY HEALTH CARE - CDA

REGULAR POLICY CHANGE NUMBER:	17
IMPLEMENTATION DATE:	7/1984
ANALYST:	Shelley Stankeivicz
FISCAL REFERENCE NUMBER:	24

	FY 2006-07	FY 2007-08
FULL YEAR COST - TOTAL FUNDS	$393,815,000	$395,175,000
- STATE FUNDS	$196,907,500	$197,587,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$393,815,000	$395,175,000
STATE FUNDS	$196,907,500	$197,587,500
FEDERAL FUNDS	$196,907,500	$197,587,500

DESCRIPTION

Adult Day Health Care (ADHC) is a community-based day program providing health, therapeutic, and social services designed to serve those at risk of being placed in a nursing home. The ADHC Program is funded via the Medi-Cal budget with State General Fund and Title XIX federal funds. Currently, the Department performs the licensing of Medi-Cal ADHCs. Beginning July 1, 2007, the California Department of Public Health will perform the licensing of these facilities. The Department of Aging (CDA) administers the program and certifies each center for Medi-Cal reimbursement.

In December 2003 CMS notified the Department that the ADHC program must be approved under a waiver or SPA with specified changes to the program in order to continue receiving federal funding. SB 1755, which was signed by the Governor in September of 2006, authorizes the Department to make major reforms to the ADHC program over the next three years. A SPA will be submitted to CMS in 2009 that details the authorized reforms.

This policy change includes the impact of the Budget Act and Health Trailer Bill of 2004, which implemented a twelve-month moratorium on the certification of new Adult Day Health Care centers effective August 16, 2004, including in-house applications, with specified exceptions. The Budget Act and Health Trailer Bill of 2005 included language to allow specific additional exemptions to the moratorium. State law [W&I code, Section 14043.46(g)] makes annual renewal of the moratorium the purview of the Director. In August 2006, the moratorium was extended for FY 2006-07, and it is anticipated to be extended for FY 2007-08.

1. ADHC rates are increased each year by the same percentage as the NF-A weighted average rate increase.

2. The average monthly cost per ADHC user is expected to be $971.95 during FY 2006-07 and $974.24 during FY 2007-08. This is based on paid claims data for the 2006 calendar year and assumes a 3.62% cost increase from FY 2005-06 to FY 2006-07. The FY 2007-08 estimate includes the full-year impact of the FY 2006-07 increase.

3. The actual average monthly users for FY 2005-06 were 37,404.

ADULT DAY HEALTH CARE - CDA

REGULAR POLICY CHANGE NUMBER: 17

4. The projected average monthly users for FY 2006-07 are 33,765.

5. Projected average monthly users for FY 2007-08 are 33,802. Projected participants in FY 2007-08 assume the ADHC moratorium is extended for FY 2007-08.

FY 2006-07 cost:
33,765 x 12 months x $971.95 = **$393,815,000**

FY 2007-08 cost:
33,802 x 12 months x $974.24 = **$395,175,000**

LOCAL EDUCATION AGENCY (LEA) PROVIDERS

REGULAR POLICY CHANGE NUMBER:	18
IMPLEMENTATION DATE:	7/2000
ANALYST:	Betty Lai
FISCAL REFERENCE NUMBER:	25

	FY 2006-07	FY 2007-08
FULL YEAR COST - TOTAL FUNDS	$153,000,000	$175,000,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$153,000,000	$175,000,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$153,000,000	$175,000,000

DESCRIPTION

Local Educational Agencies (LEAs) can become Medi-Cal providers and submit claims to be reimbursed for health services provided to Medi-Cal eligible students in schools within their jurisdictions. The Medi-Cal program provides federal matching funds.

State Plan Amendment (SPA) 03-024, approved in March 2005, implemented a new methodology for reimbursement in June 2006. Interim rates based on a rate study will be used for covered LEA services, and costs will be reconciled against reimbursements. As a result of this SPA, increased payments will be made to existing providers and additional payments will be made to new providers.

AB 2950 (Chapter 131, Statutes of 2006) will result in an increase in provider payments due to the elimination of the 25% and 50% late invoice submission penalties effective with service dates beginning January 1, 2007.

This policy change reflects FMAP changes.

MULTIPURPOSE SENIOR SERVICES PROGRAM-CDA

REGULAR POLICY CHANGE NUMBER: 19
IMPLEMENTATION DATE: 7/1984
ANALYST: Shelley Stankeivicz
FISCAL REFERENCE NUMBER: 28

	FY 2006-07	FY 2007-08
FULL YEAR COST - TOTAL FUNDS	$50,516,000	$50,516,000
- STATE FUNDS	$25,258,000	$25,258,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$50,516,000	$50,516,000
STATE FUNDS	$25,258,000	$25,258,000
FEDERAL FUNDS	$25,258,000	$25,258,000

DESCRIPTION

The Multipurpose Senior Services Program is designed to evaluate the effects of providing a comprehensive array of social and health services to persons 65 or older who are "at risk" of long-term care. The program provides services under a federal home and community-based services waiver to an average of 16,335 clients in 11,789 client slots, at $4,285 per year per client slot.

The Department pays the MSSP claims, and prior to FY 2006-07, both the GF and FFP were budgeted in the Department's budget. The Budget Act of 2006 removed the GF ($22,257,500) from the Department's budget and included it in the CDA budget beginning with FY 2006-07. The Budget Act also increased the Department's reimbursement authority so that the CDA GF can be transferred back to the Department as a reimbursement at the beginning of the fiscal year and the Department can pay the MSSP claims.

In addition, the Budget Act of 2006 enacted by the Legislature increased the total funding for the MSSP program by $6,000,000, for a total fund amount of $50,516,000.

FY 2006-07

	TF	**Reimbursement From CDA**	**FFP**
MSSP	**$50,516,000**	**$25,258,000**	**$25,258,000**

FY 2007-08

	TF	**Reimbursement From CDA**	**FFP**
MSSP	**$51,516,000**	**$25,258,000**	**$25,258,000**

CONLAN V. BONTA

REGULAR POLICY CHANGE NUMBER:	20
IMPLEMENTATION DATE:	4/2007
ANALYST:	Stella Bertrand
FISCAL REFERENCE NUMBER:	34

	FY 2006-07	FY 2007-08
FULL YEAR COST - TOTAL FUNDS	$958,000	$18,211,000
- STATE FUNDS	$479,000	$9,105,500
PAYMENT LAG	0.6400	0.9750
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$613,100	$17,755,700
STATE FUNDS	$306,560	$8,877,860
FEDERAL FUNDS	$306,560	$8,877,860

DESCRIPTION

In *Conlan, Schwarzmer and Stevens v. Bontá*, the Court of Appeals found that the Department failed to provide a procedure whereby Medi-Cal beneficiaries can be reimbursed for the amount they paid, not to exceed the rate established for that service under the Medi-Cal program, for services received during the period in which their applications were pending, or any of the 3 months prior to the month of application in which they were eligible, or for which they had to pay a copayment when using other health care coverage, or when a denial of eligibility is reversed by a hearing. On November 16, 2006, the court approved a plan setting up a procedure through which beneficiaries who are unable to get reimbursement from the provider for their out-of-pocket expenses can receive direct reimbursement.

Assumptions:

1. The *Conlan* reimbursement plan was implemented in December 2006 and reimbursements to claimants began in April 2007.

New Beneficiaries:

1. Based on a study of Medi-Cal beneficiaries who were newly eligible in March 2002, there were 5,991,271 Medi-Cal beneficiaries in that month, of which 202,000 (3.4%) were new eligibles.
2. Of the new beneficiaries in that month, 1,000 (0.02% of total eligibles) were eligible for one of the three months prior to the month they applied for Medi-Cal. They were all fee-for-service.
3. The average monthly cost for retroactive month eligibility was $729.
4. Of the new beneficiaries in that month, about 155,000 (2.6% of total eligibles) were determined eligible after the month of application.
5. The average monthly cost for beneficiaries determined eligible after the month of application was $352.
6. Based on data on applications received daily from 2003, there are 5,000 new beneficiaries added daily. 25% are heads of household are expected to file a claim.

5,000 x .25 households x .25 file claim	=	313	claims per day
313 x 5 days x 52 weeks	=	81,380	claims per year

7. Assume 1% of the claims will be for retroactive months.
8. Assume the cost per claim will be the average monthly cost for a retroactive or pre-determination of eligibility month.

9. The annual cost is expected to be:

CONLAN V. BONTA

REGULAR POLICY CHANGE NUMBER: 20

81, 380 x .01 x $729 =	$593,260	
81, 380 x .99 x $352 =	$28,359,302	
	$28,953,000	($2,412,750 monthly)

10. Assume the cost in 2006-07 and 2007-08 will be mainly reimbursement for out-of-pocket costs for persons eligible for Medi-Cal from June 1997 through June 2006 that are required to be notified of the availability of reimbursement under the provisions of the *Conlan* court order. These costs are expected to be limited due to the fact that it will be difficult to contact beneficiaries for these retroactive periods and the fact that beneficiaries must have receipts to file a claim. As both the beneficiaries and providers are educated on the requirements for providers to repay Medi-Cal beneficiaries for out-of-pocket expenses incurred prior to the determination of eligibility, costs for Conlan are expected to be the annual costs identified above. Assuming a 24-month phase in before monthly costs get to the ongoing level, costs are expected to be:

$2,412,750 / 24-month phase in	=	$100,531
$100,531 X 6(3+2+1 months)	=	$603,186
FY 2006-07 Costs	**=**	**$703,717**

$100,531 X 3 month growth in FY 2006-07 X 12 months	=	$3,619,116
$100,531 X 78 (12+11+…..1 months)	=	$7,841,418
FY 2007-08 Costs	**=**	**$11,460,534**

Copayments for Beneficiaries with Other Health Coverage:

1. Assume that the 196,000 FFS beneficiaries with other health care coverage other than Healthy Families coverage are also beneficiaries impacted by *Conlan*.
2. 58% are users each month.
3. Assume 25% will be charged copays and request reimbursement.
4. Based on the average number of services per user per month from the May 2006 Estimate, assume the average number of copays per claim is 5.
5. Assume the average cost per copay is $10.
6. The annual cost is expected to be:

196,000 x .58 users x .25 with copays who file claims =	28,420	
28,420 x $10 per copay x 5 copays x 12 months =	$17,052,000	($1,421,000 monthly)

7. The costs that include a 24-month phase in are expected to be:

$17,052,000 / 12 months	=	$1,421,000
$1,421,000 / 24 phase in	=	$59,208
$59,208 X 6 (3+2+1 months)	=	$355,248
FY 2006-07 Costs	**=**	**$1,835,456**

$59,208 X 3 month growth in FY 2006-07 X 12 months	=	**$2,131,488**
$59,208 X 78 (12+11+…..1 months)	=	**$4,618,224**
FY 2007-08 Costs	**=**	**$6,749,712**

	FY 2006-07		FY 2007-08	
	Total	**GF**	**Total**	**GF**
New Eligibles	**$603,000**	$301,500	**$11,461,000**	$5,730,500
Copayment	**$355,000**	$177,500	**$6,750,000**	$3,375,000
Total	**$958,000**	**$479,000**	**$18,211,000**	**$9,105,500**

HUMAN PAPILLOMAVIRUS VACCINE

REGULAR POLICY CHANGE NUMBER: 21
IMPLEMENTATION DATE: 1/2007
ANALYST: Julie Chan
FISCAL REFERENCE NUMBER: 1141

	FY 2006-07	FY 2007-08
FULL YEAR COST - TOTAL FUNDS	$5,737,000	$11,474,000
- STATE FUNDS	$2,868,500	$5,737,000
PAYMENT LAG	0.6210	0.9810
% REFLECTED IN BASE	7.70 %	1.20 %
APPLIED TO BASE		
TOTAL FUNDS	$3,288,400	$11,120,900
STATE FUNDS	$1,644,180	$5,560,460
FEDERAL FUNDS	$1,644,180	$5,560,460

DESCRIPTION

The Food and Drug Administration (FDA) approved the first vaccine for cervical cancer prevention, human papillomavirus (HPV) vaccine (Gardasil™), for non-pregnant females, ages 9 to 26 years. Effective with provider notification, Medi-Cal will be covering quadrivalent (four strain types) HPV vaccine to prevent HPV infection, strains of which have been identified as the cause of cervical cancer. The Department expects that this vaccine will be covered under the federal Vaccines for Children (VFC) Program for females age 9 to 18 years of age. The vaccine is administered in 3 intramuscular injections over 6 months and is most effective when administered prior to becoming sexually active. For VFC funded vaccine, Medi-Cal will pay providers a $9 administration fee. For females not covered under VFC, Medi-Cal will pay the full cost of the three-dose series. This benefit is expected to began in January 2007.

Assumptions:

1. The cost of the $9 administration fee for Medi-Cal beneficiaries under 19 years of age is expected to be minor. Therefore, it is not included in this policy change.

2. There are approximately 52,036 female Medi-Cal beneficiaries ages 19-26, who are in categories other than the family categories and would potentially get the vaccine.

3. The cost of providing the vaccine to Medi-Cal eligible patients is $147 per dose. The cost also includes the administration fee. $147 x 3 = $441.

4. The percentage of females 19-26 who will elect to receive the vaccines is not known. For purposes of this estimate, 50% is assumed.
   52,036 x .5 x $441 = $11,474,000 annual costs.

5. 64% are Fee For Service and 36% are enrolled in Managed Care.

HUMAN PAPILLOMAVIRUS VACCINE

REGULAR POLICY CHANGE NUMBER: 21

FY 2006-07	FFP	GF	Total
FFS	$1,836,000	$1,836,000	$3,672,000
Managed Care	$1,033,000	$1,032,000	$2,065,000
Total	**$2,869,000**	**$2,868,000**	**$5,737,000**

FY 2007-08	FFP	GF	Total
FFS	$3,672,000	$3,672,000	$7,427,000
Managed Care	$2,065,000	$2,065,000	$4,090,000
Total	**$5,737,000**	**$5,737,000**	**$11,474,000**

PRENATAL SCREENING EXPANSION

REGULAR POLICY CHANGE NUMBER:	22
IMPLEMENTATION DATE:	1/2007
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1139

	FY 2006-07	FY 2007-08
FULL YEAR COST - TOTAL FUNDS	$5,686,000	$11,374,000
- STATE FUNDS	$2,843,000	$5,687,000
PAYMENT LAG	0.6210	0.9810
% REFLECTED IN BASE	23.07 %	12.06 %
APPLIED TO BASE		
TOTAL FUNDS	$2,716,400	$9,812,300
STATE FUNDS	$1,358,200	$4,906,120
FEDERAL FUNDS	$1,358,200	$4,906,130

DESCRIPTION

SB 1555 (Chapter 484, Statutes of 2006) expands current prenatal screening from screening using the triple serum marker test in the second trimester (maternal serum alpha-fetoprotein (AFP)), human chorionic gonadotrophin(hCG), and unconjugated estriol (uE3) to screening pregnant women using the quadruple serum marker test that consists of the triple serum marker test plus inhibin A, during the first trimester of pregnancy. The addition of inhibin A to prenatal screening increases the detection of Down's Syndrome from 77% to 83%. SB 1555 authorizes a $40 increase in the current prenatal screening fee to be deposited into the Genetic Disease Testing Fund and a $10 fee increase for the California Birth Defects Monitoring Program (CBDMP). The increased fees began in January 2007.

Assumptions:

1. The Department estimates 505,507 prenatal screening tests in FY 2006-07. Approximately 45% of them are paid for by Medi-Cal.

   505,507 x .45 = 227,478

2. Based on the Medi-Cal Delivery Report for 2004, 73% of Medi-Cal births are paid for by FFS and 27% by managed care.

   227,478 x .73 = 166,059 FFS screens
   227,478 x .27 = 61,419 Managed Care screens

3. Assume the same number of tests for FYs 2006-07 and 2007-08.

4. The additional cost per screen will be $50.

   166,059 X $50 = $ 8,303,000 Annual FFS costs
   61,419 X $50 = $ 3,071,000 Annual Managed Care costs
   $11,374,000 Total costs

PRENATAL SCREENING EXPANSION

REGULAR POLICY CHANGE NUMBER: 22

5. 2006-07 costs begin in January 2007 and are one-half the annual costs.

FY 2006-07	**FFP**	**GF**	**Total**
FFS	$2,075,500	$2,075,500	$4,151,000
Managed Care	$767,500	$767,500	$1,535,000
Total	$2,843,000	$2,843,000	**$5,686,000**

FY 2007-08	**FFP**	**GF**	**Total**
FFS	$4,151,500	$4,151,500	$8,303,000
Managed Care	$1,535,000	$1,535,000	$3,071,000
Total	$5,088,500	$5,088,500	**$11,374,000**

NF A/B LEVEL OF CARE GROWTH

REGULAR POLICY CHANGE NUMBER:	23
IMPLEMENTATION DATE:	5/2007
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1160

	FY 2006-07	FY 2007-08
FULL YEAR COST - TOTAL FUNDS	$150,000	$3,900,000
- STATE FUNDS	$75,000	$1,950,000
PAYMENT LAG	0.3623	0.8942
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$54,300	$3,487,400
STATE FUNDS	$27,170	$1,743,690
FEDERAL FUNDS	$27,170	$1,743,690

DESCRIPTION

There are 213 individuals from the Nursing Facility A/B waiting list currently being assessed for enrollment in the Nursing Facility/Acute Hospital (NF/AH) Waiver at the NF A/B Level of Care (LOC). The Department expects to enroll the individuals being assessed at a rate of approximately 28 per month.

Assumptions:

1. Based on actual costs for persons on the waiting list for the period July 2004 through June 2005, pre-waiver costs for waiver impacted services for those on the waiting list being assessed for enrollment are $14,588 annually.

2. Waiver costs are currently capped at $35,948 for NF B LOC (a separate policy change increases the cap for all persons in the NF/AH Waiver at the NF B LOC to $48,180 beginning July 2007).

3. Assessments for persons on the waiting list began in October 2006. Waiver costs for these persons are estimated to begin in May 2007. It is anticipated that there will be 91 additional beneficiaries enrolled in the waiver by the end of FY 2006-07 and that all 213 will be enrolled by December 2007.

4. Waiver costs will be $21,360 ($35,948-$14,588) per person per year before the addition of the cap increase. Payment lags have been applied to the cost and savings below.

NF A/B LEVEL OF CARE GROWTH

REGULAR POLICY CHANGE NUMBER: 23

	FY 2006-07		FY 2007-08	
Lagged Costs	TF	GF	TF	GF
From Community Waitlist				
Waiver Services	$67,700	$33,850	$5,474,000	$2,737,000
County Inpatient	-1,100	-550	-231,000	-115,500
Community Inpatient	-9,100	-4,550	-1,497,000	-748,500
DME	1,500	750	120,000	60,000
Adult Day Health Care Centers	-400	-200	-30,000	-15,000
Other Providers (non-professional)	-1,500	-750	-115,000	-57,500
Medically Required Transportation	-400	-200	-29,000	-14,500
Home Health Agencies	-1,000	-500	-111,000	-55,500
Intermediate Care Facility	-1,100	-550	-58,000	-29,000
AIDS Waiver Services	-100	-50	-4,000	-2,000
Nursing Facility (SNF)	-500			

GENETIC DISEASE TESTING FEE INCREASE

REGULAR POLICY CHANGE NUMBER:	25
IMPLEMENTATION DATE:	1/2007
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1170

	FY 2006-07	FY 2007-08
FULL YEAR COST - TOTAL FUNDS	$1,672,000	$3,344,000
- STATE FUNDS	$836,000	$1,672,000
PAYMENT LAG	0.6210	0.9810
% REFLECTED IN BASE	23.07 %	12.06 %
APPLIED TO BASE		
TOTAL FUNDS	$798,800	$2,884,800
STATE FUNDS	$399,390	$1,442,420
FEDERAL FUNDS	$399,390	$1,442,420

DESCRIPTION

Effective January 1, 2007, the newborn and prenatal genetic screening fees will each increase an additional $7.00. This increase is in accordance with Health and Safety Code Section 124977 which requires the program to be fully supported from fees collected and states that the amount of the fee shall be established by regulation and periodically adjusted by the Director.

Assumptions:

1. The Department estimates 505,507 prenatal screening tests and 556,078 newborn screens will be provided in FY 2006-07. The same number of tests is assumed for FY 2007-08. Approximately 45% of them are paid for by Medi-Cal.

2. The additional cost per screen will be $7.

FY 2006-07		
505,507 x .45 x $7.00 x .5		= $796,000 Prenatal screen costs
556,078 x .45 x $7.00 x .5		= $876,000 Newborn screen costs
	Total	= $1,672,000

FY 2007-08		
505,507 x .45 x $7.00		= $1,592,000 Prenatal screen costs
556,078 x .45 x $7.00		= $1,752,000 Newborn screen costs
	Total	= $3,344,000

3. Based on the Medi-Cal Delivery Report for 2004, 73% of Medi-Cal births are paid for by FFS and 27% by managed care. Based on this ratio, the cost of managed care tests is $451,000 in FY 2006-07 and $903,000 in FY 2007-08.

GENETIC DISEASE TESTING FEE INCREASE

REGULAR POLICY CHANGE NUMBER: 25

FY 2006-07	**FFP**	**GF**	**Total**
FFS	$610,500	$610,500	$1,221,000
Managed Care	$225,500	$225,500	$451,000
Total	**$836,000**	**$836,000**	**$1,672,000**

FY 2007-08	**FFP**	**GF**	**Total**
FFS	$1,220,500	$1,220,500	$2,441,000
Managed Care	$451,500	$451,500	$903,000
Total	**$1,672,000**	**$1,672,000**	**$3,344,000**

ELIMINATION OF PODIATRY TARS

REGULAR POLICY CHANGE NUMBER:	27
IMPLEMENTATION DATE:	10/2006
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1122

	FY 2006-07	FY 2007-08
FULL YEAR COST - TOTAL FUNDS	$150,000	$200,000
- STATE FUNDS	$75,000	$100,000
PAYMENT LAG	0.7870	0.9960
% REFLECTED IN BASE	62.18 %	44.01 %
APPLIED TO BASE		
TOTAL FUNDS	$44,600	$111,500
STATE FUNDS	$22,320	$55,770
FEDERAL FUNDS	$22,320	$55,770

DESCRIPTION

The Health Budget Trailer Bill of 2006 amended the Welfare and Institutions Code to remove certain podiatry services from prior authorization. Prior to implementation of this legislation, podiatric office visits were covered as medically necessary and all other outpatient and inpatient podiatry services were subject to prior authorization and limited to medical and surgical services necessary to treat disorders of the feet, ankles, or tendons that insert into the foot, secondary to or complicating chronic medical diseases, or which significantly impair the ability to walk.

The Health Budget Trailer Bill provides that prior authorization for podiatric services on an outpatient basis will not be required if:

1. The services are provided by a doctor of podiatric medicine acting within the scope of his or her practice;
2. The services are related to trauma, infection management, pain control, wound management, diabetic foot care, or limb salvage;
3. The services are medically necessary;
4. An urgent or emergency need for the services exists;
5. The patient was referred to the podiatrist by a physician, and
6. Prior authorization is not required for a physician providing the same service.

The Budget Act of 2006, as enacted by the Legislature, added $200,000 ($100,000 GF) to fund this change. The W&I Code eliminated the existing TAR requirements effective for dates of services on or after October 1, 2006.

ELIMINATION OF PODIATRY TARS

REGULAR POLICY CHANGE NUMBER: 27

	Total Funds	GF	FF
FY 2006-07	**$150,000**	**$75,000**	**$75,000**
FY 2007-08	**$200,000**	**$100,000**	**$100,000**

NEW SERVICES FOR NF/AH & IHO WAIVERS

REGULAR POLICY CHANGE NUMBER:	28
IMPLEMENTATION DATE:	5/2007
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1130

	FY 2006-07	FY 2007-08
FULL YEAR COST - TOTAL FUNDS	$77,000	$248,000
- STATE FUNDS	$38,500	$124,000
PAYMENT LAG	0.3450	0.9450
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$26,600	$234,400
STATE FUNDS	$13,280	$117,180
FEDERAL FUNDS	$13,280	$117,180

DESCRIPTION

The Department added new services and provider types previously approved by CMS in the NF A/B, NF Subacute and In-Home Medical Care (IHMC) waivers. The NF/Subacute and IHMC Waivers were combined with the NF A/B Waiver and the name was changed to Nursing Facility/Acute Hospital (NF/AH) Waiver. The new services are:

- Respite-Facility
- Respite
- Transitional Case Management
- Community Transition Services
- Habilitation Services

Procedure codes for Respite-Facility, Respite, and Transitional Case Management were operational on November 1, 2006. The Department expects the procedure codes for Community Transition Services and Habilitation Services to be operational be May 1, 2007.

No increase in costs resulting from the implementation of new services and provider types is expected for the NF/AH, NF A/B LOC, and the IHO Waivers, as beneficiaries enrolled in those waivers currently expend up to their waiver budget cap with the current service package. The addition of these new services and provider types merely allows beneficiaries to choose the service/provider that best fits their needs. For the Subacute and Hospital LOC, there will be cost increases for these new services and provider types as follows:

NEW SERVICES FOR NF/AH & IHO WAIVERS

REGULAR POLICY CHANGE NUMBER: 28

Service	IHMC Annual Costs	NF SA Annual Costs	FY 2006-07 Total Costs (3/07 – 6/07)	FY 2007-08 Total
Respite - Facility	$0.00	$24,000	$8,000	$24,000
Respite	$29,000	$137,000	$56,000	$166,000
Transitional Case Management	$2,000	$19,000	$7,000	$21,000
Community Transition Services	$16,000	$15,000	$5,000	$31,000
Habilitation Services	$2,000	$4,000	$1,000	$6,000
Total	$49,000	$199,000	**$77,000**	**$248,000**

INDEP. PLUS SELF-DIR. SERV. WAIVER - CDDS

REGULAR POLICY CHANGE NUMBER:	30
IMPLEMENTATION DATE:	1/2008
ANALYST:	Stella Bertrand
FISCAL REFERENCE NUMBER:	1172

	FY 2006-07	FY 2007-08
FULL YEAR COST - TOTAL FUNDS	$0	$312,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$312,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$312,000

DESCRIPTION

The Department is applying for a federal Centers for Medicare & Medicaid Services (CMS) 1915(c) Home and Community-Based Services Waiver. The proposed waiver for the expansion of California Department of Developmental Services' (CDDS) Self-Directed Services project, known as the Self-Directed Services /Home and Community-Based Services (SDS/HCBS) Waiver, will allow participating Medi-Cal beneficiaries to receive an individual budget allocation that will result, in the aggregate, in a cost savings to the State General Fund. Self-directed services enable beneficiaries to have more control of their services and to manage a finite amount of funds allocated to an individual budget in order to pay for services specified in the beneficiary's Individual Program Plan. It is expected to implement in January 2008.

The CDDS budget is on an accrual basis, while the CDHS budget is on a cash basis. The following cash estimate has been provided by CDDS.

CASH BASIS

	CDHS FFP	CDDS GF	IA#
FY 2007-08	**$312,000**	$312,000	Pending

NEWBORN HEARING SCREENS EXPANSION

REGULAR POLICY CHANGE NUMBER:	31
IMPLEMENTATION DATE:	1/2008
ANALYST:	Betty Lai
FISCAL REFERENCE NUMBER:	1131

	FY 2006-07	FY 2007-08
FULL YEAR COST - TOTAL FUNDS	$0	$1,307,000
- STATE FUNDS	$0	$653,500
PAYMENT LAG	1.0000	0.2269
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$296,600
STATE FUNDS	$0	$148,280
FEDERAL FUNDS	$0	$148,280

DESCRIPTION

Existing statute requires general acute care hospitals with California Children's Services (CCS)-approved licensed perinatal services to offer hearing screening to parents of all newborns delivered at these hospitals.

AB 2651 (Chapter 335, Statutes of 2006) mandates that all general acute care hospitals, with licensed perinatal services and at least 100 births per year, participate in the California Newborn Hearing Screening Program (NHSP) and administer a hearing screening test to all newborns upon birth admission. General acute care hospitals with licensed perinatal services that are not CCS-approved and have fewer than 100 births per year will either provide a hearing screening test or contract with an outpatient infant hearing screening provider certified by the Department to provide hearing screening tests.

Assumptions:

1. The statute is effective January 1, 2008.
2. The Department is assuming hospitals that are not CCS-approved may be providing the screens, but are not yet being reimbursed.
3. Assume effective January 1, 2008, all hospitals that are not CCS-approved will be providing the screens.
4. Assume a hearing screening cost of $30 per infant.

NEWBORN HEARING SCREENS EXPANSION

REGULAR POLICY CHANGE NUMBER: 31

5. Based on deliveries at approximately 100 hospitals not currently CCS-approved, assume that an additional 132,400 inpatient infants will be screened annually by hospital staff. Assume that 60,904 (46%) of these infants will be covered by Medi-Cal, 5,296 (4%) will be covered by CCS State Only funding, and 66,200 (50%) will be covered by private health insurance.

   60,904 x $30 = $1,827,000 annually
   $1,827,000 / 12 = $152,250 monthly

   FY 2007-08: $152,250 x 6 = $913,500 ($456,750 GF)

6. Assume that 1,840 (3%) of the Medi-Cal infants yearly will not pass the inpatient birth screening and will require outpatient hearing screening after discharge. Medi-Cal local assistance costs for the increased volume of outpatient hearing screens are estimated to be:

   1,840 x $30 = $55,200 annually
   $55,200 / 12 = $4,600 monthly

   FY 2007-08: $4,600 x 6 = $27,600 ($13,800 GF)

7. Of the 1,840 outpatient infants, assume that 610 (one-third) will not pass the outpatient hearing screening and will require a diagnostic hearing evaluation. Medi-Cal local assistance costs for the increased volume of diagnostic hearing evaluations, at a cost of $1,000 per evaluation, are estimated to be:

   610 x $1,000 = $610,000 annually
   $610,000 / 12 = $50,833 monthly

   FY 2007-08: $50,833 x 6 = $304,998 ($152,499 GF)

8. Of the 610 infants with diagnostic evaluation, assume that 122 (20%) will need medical interventions (e.g., hearing aids and speech and audiology services). Medi-Cal local assistance costs for the increased volume of medical interventions, at a cost of $1,000 per intervention, are estimated to be:

   122 x $1,000 = $122,000 annually
   $122,000 / 12 = $10,167 monthly

   FY 2007-08: $10,167 x 6 = $61,002 ($30,501 GF)

FY 2007-08	**TF**	**GF**
Inpatient hearing screens	$913,500	$456,750
Outpatient hearing screens	$27,600	$13,800
Diagnostic hearing evaluations	$304,998	$152,499
Medical interventions	$61,002	$30,501
TOTAL	**$1,307,000**	**$653,500**

FAMILY PACT STATE ONLY SERVICES

REGULAR POLICY CHANGE NUMBER: 32
IMPLEMENTATION DATE: 7/2006
ANALYST: Betty Lai
FISCAL REFERENCE NUMBER: 1164

	FY 2006-07	FY 2007-08
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$2,500,000	$2,500,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$2,500,000	$2,500,000
FEDERAL FUNDS	-$2,500,000	-$2,500,000

DESCRIPTION

CMS has informed the Department that FFP will no longer be available for several services that have been part of the Family PACT program benefit package. These include mammography, Hepatitis B vaccines, five procedures related to complications of particular contraceptive methods, and diagnostic testing to distinguish cancer from genital warts.

Many of these services are necessary to diagnose cancer and prevent and treat contraceptive complications, and are part of nationally accepted standards of care and responsible clinical practice. Therefore, the services will continue to be provided with 100% State GF.

The estimated annual fiscal impact to the State for the loss of FFP for these benefits is $2,500,000 GF.

	TF	GF	FFP
Current Funding	$5,000,000	$2,500,000	$2,500,000
New Funding	$5,000,000	$5,000,000	$ 0
Net Change	**$ 0**	**+$2,500,000**	**-$2,500,000**

SCHIP FUNDING FOR PRENATAL CARE

REGULAR POLICY CHANGE NUMBER:	34
IMPLEMENTATION DATE:	7/2005
ANALYST:	Betty Lai
FISCAL REFERENCE NUMBER:	1007

	FY 2006-07	FY 2007-08
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	-$128,067,550	-$111,566,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	-$128,067,550	-$111,566,000
FEDERAL FUNDS	$128,067,550	$111,566,000

DESCRIPTION

In order to maximize revenues, the 2005-06 Budget Act and AB 131 (Chapter 80, Statutes of 2005), the Health Trailer Bill, required MRMIB to file a State Plan Amendment (SPA) in the State Children's Health Insurance Program (SCHIP) to claim 65% federal funding for prenatal care provided to women previously ineligible for federal funding for this care. The cost for this care had been 100% General Fund.

Assumptions:

1. The cost of prenatal care for undocumented women was $136,301,000 in FY 2004-05; and was $149,643,000 in FY 2005-06 and is estimated to be $162,101,000 in FY 2006-07.

2. SCHIP funding for May and June 2006 costs was not claimed in FY 2005-06; therefore, it will be budgeted in FY 2006-07. The one-time costs are $25,387,000.

3. Based on the actual and estimated costs, the following amounts are budgeted for FY 2006-07 and FY 2007-08:

FY 2006-07:	($162,101,000 + 25,387,000) x .65 SCHIP FFP =	$121,867,200 FFP
FY 2007-08:	$162,101,000 x .65 SCHIP FFP =	$105,365,650 FFP

4. The cost of prenatal care for legal immigrants who have been in the country for less than five years was $8,984,000 in FY 2004-05 and $9,539,000 in FY 2005-06. Based on the actual costs, assume FY 2006-07 and FY 2007-08 are the same as FY 2005-06.

FY 2006-07:	$9,539,000 x .65 SCHIP FFP =	$6,200,350 FFP
FY 2007-08:	$9,539,000 x .65 SCHIP FFP =	$6,200,350 FFP

SCHIP FUNDING FOR PRENATAL CARE

REGULAR POLICY CHANGE NUMBER: 34

5. The federal funding received on a cash basis will be:

FY 2006-07 Savings:	$121,867,200 + $6,200,350 =	**$128,067,550**
FY 2007-08 Savings:	$105,365,650 + $6,200,350 =	**$111,566,000**

**Funding for prenatal care for undocumented women, and for legal immigrants who have been in the country for less than five years, has been shifted from the Medi-Cal Item, 4260-101, to the Healthy Families Item, 4260-113.

CDSS SHARE OF COST PAYMENT FOR IHSS

REGULAR POLICY CHANGE NUMBER:	35
IMPLEMENTATION DATE:	11/2005
ANALYST:	Stella Bertrand
FISCAL REFERENCE NUMBER:	1067

	FY 2006-07	FY 2007-08
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$4,986,500	$4,986,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$4,986,500	$4,986,500
FEDERAL FUNDS	-$4,986,500	-$4,986,500

DESCRIPTION

The California Department of Social Services (CDSS) and the California Department of Health Services (CDHS) have implemented a process that enables Medi-Cal In-Home Supportive Services (IHSS) recipients who have a Medi-Cal share-of-cost (SOC) higher than their IHSS SOC to be eligible for Medi-Cal at the beginning of each month. Each IHSS recipient with a Medi-Cal SOC that exceeds his/her IHSS SOC must meet the Medi-Cal SOC obligation to establish Medi-Cal eligibility.

Prior to the complete automation in June 2006 of the Case Management, Information, and Payrolling System (CMIPS), the IHSS payroll computer system, an interim process reconciled the difference between the IHSS and Medi-Cal SOC. Based on an Interagency Agreement (IA) CDSS transferred funds to CDHS to pay the Medi-Cal SOC for IHSS recipients. CDHS repaid the federal government the FFP for the services that should have been paid by the beneficiary as part of the SOC.

Once CMIPS became fully automated in June 2006, CDSS began funding services for each IHSS recipient in an amount equal to the difference between the monthly Medi-Cal SOC and the IHSS SOC.

The projected amounts to be reimbursed from the IHSS SOC fund, Item 4260-601-0942001 are included in the Management Summary funding pages as part of Reimbursements, Item 4260-610-0995 and are:

	CDSS Payment
FY 2006-07	$9,973,000
FY 2007-08	$9,973,000

This policy change reflects the repayment to the federal government:

	FFP Repayment
FY 2006-07	**$4,986,500**
FY 2007-08	**$4,986,500**

ADULT DAY HEALTH CARE REFORMS

REGULAR POLICY CHANGE NUMBER:	36
IMPLEMENTATION DATE:	1/2008
ANALYST:	Shelley Stankeivicz
FISCAL REFERENCE NUMBER:	1074

	FY 2006-07	FY 2007-08
FULL YEAR COST - TOTAL FUNDS	$0	-$9,250,000
- STATE FUNDS	$0	-$4,625,000
PAYMENT LAG	1.0000	0.6906
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	-$6,388,000
STATE FUNDS	$0	-$3,194,020
FEDERAL FUNDS	$0	-$3,194,020

DESCRIPTION

The current reimbursement rate for Adult Day Health Care (ADHC) was set at 90% of the nursing facility (NF)-level A rate and is increased each year by the same percentage as the weighted average NF-A percentage increase. This is a bundled, all-inclusive rate for all ADHC services which was set by a court settlement in 1993. As authorized by SB 1755 (Chapter 691, Statutes of 2006), the following reforms will be instituted:

1. Unbundling the rate into its component services, and retaining the cap of 90% of the NF-A rate. Only the remaining bundled procedure code that includes overhead and unskilled services would require prior authorization, and ADHCs would "bill direct" for ancillary and skilled services.

2. Tightening medical necessity criteria.

3. Performing post-payment reviews of participant charts by CDA during their regular surveys to ensure that services billed and paid for were actually provided and were medically necessary.

4. Changing reimbursement to a prospective cost-based methodology.

5. Clarifying the role of the patient’s personal care doctor and that of the staff doctor at the ADHC center.

Of these reforms, only tightening of medical necessity criteria is anticipated to be in place during FY 2007-08. It is anticipated to be in place on January 1, 2008.

ADULT DAY HEALTH CARE REFORMS

REGULAR POLICY CHANGE NUMBER: 36

Assumptions:

1. Assume 30% of new users and 15% of old users will not meet medical criteria. Currently, the average monthly number of new users is 2,366. The average monthly number of old users is 31,436. A savings of 30% and 15%, respectively, results in a reduction of 5,425 total monthly users as follows:

Average Monthly Reduction of New Users	= 2,366 x .30 =	710
Average Monthly Reduction of Old Users	= 31,436 x .15 =	4,715
Total Monthly Reduction in Users	=	5,425

2. Assume 50% of users who do not initially meet medical criteria successfully appeal or reduce the number of days in ADHC, resulting in a net reversal of 15% of new users and 7.5% of old users as follows:

Average Monthly Reversals (New Users)	= 710 x .50 =	355
Average Monthly Reversals (Old Users)	= 4,715 x .50 =	2,358
Total Monthly Reversals	= =	2,713

3. Assume the average monthly cost per participant is $974.24.

   Annual Unlagged Savings = $974.24 x 2,713 x 12 months = $31,717,357

	Annual Savings		**FY 2007-08 Savings (lagged)**	
(Dollars in Thousands)	**TF**	**GF**	**TF**	**GF**
Tighten Medical Necessity Criteria	**$31,717**	**$15,858**	**$6,388**	**$3,194**

EXPANSION OF NF/AH WAIVER (SB 643)

REGULAR POLICY CHANGE NUMBER: 37
IMPLEMENTATION DATE: 3/2007
ANALYST: Julie Chan
FISCAL REFERENCE NUMBER: 1129

	FY 2006-07	FY 2007-08
FULL YEAR COST - TOTAL FUNDS	-$30,000	-$433,000
- STATE FUNDS	-$15,000	-$216,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$30,000	-$433,000
STATE FUNDS	-$15,000	-$216,500
FEDERAL FUNDS	-$15,000	-$216,500

DESCRIPTION

SB 643 (Chapter 551, Statutes of 2005) requires the Department to increase the number of NF A/B Waiver slots by 500, reserving 250 for beneficiaries transitioning from facilities. The bill requires that the expansion be budget neutral to the Department. This is being done by enrolling beneficiaries from the community and facilities on a 1 to 1 basis. There is a multi-year phase-in for enrolling beneficiaries into the new waiver slots. The slot increases will be implemented on February 1, 2007.

Assumptions:

1. The Department estimates 20 Nursing Facility/Acute Hospital (NF/AH) Waiver, NF B LOC slots will be filled in fiscal year 2006-07, and 164 in 2007-08, under the provisions of SB 643.

2. For every beneficiary enrolled into the waiver from a DP-NF, one beneficiary will be enrolled from the community.

3. Based on actual costs for persons on the waiting list for the period July 2004 through June 2005, pre-waiver costs for waiver impacted services are $14,588 annually for persons on the waiting list who are currently residing in the community and $114,873 for those currently residing in DP-NFs.

4. Waiver cost will initially be capped at $35,948 for those from the community and $77,600 for those from DP-NFs.

5. Beginning in July 2007, the cap for those expansion beneficiaries coming from the community will increase from $35,948 to $48,180. This policy change includes the impact of the cap increase for those added under the provisions of SB 643. (A separate policy change increases the cap for the existing waiver slots on the NF/AH waiver.)

EXPANSION OF NF/AH WAIVER (SB 643)

REGULAR POLICY CHANGE NUMBER: 37

	FY 2006-07		FY 2007-08	
Lagged Costs	**TF**	**GF**	**TF**	**GF**
From DP-NF Waitlist				
DP-NFs	($117,000)	($58,500)	($5,440,000)	($2,720,000)
Waiver Services	65,000	32,500	3,447,000	1,723,500
	($52,000)	($26,000)	($1,993,000)	($996,500)
From Community Waitlist				
Waiver Services	$30,000	$15,000	$2,140,000	$1,070,000
County Inpatient	-1,000	-11,000	-68,000	-34,000
Community Inpatient	-6,000	-500	-436,000	-218,000
DME	1,000	500	35,000	17,500
Adult Day Health Care Centers	0	0	-9,000	-4,500
Other Providers (non-professional)	-1,000	-500	-34,000	-17,000
Medically Required Transportation	0	0	-8,000	-4,000
Home Health Agencies	-1,000	-500	-32,000	-16,000
Intermediate Care Facility	0	0	-17,000	-8,500
AIDS Waiver Services	0	0	-1,000	-500
Nursing Facility (SNF)	0	0	-10,000	-5,000
Total Costs (Rounded)	**($30,000)**	**($15,000)**	**($433,000)**	**($216,500)**

HIV/AIDS PHARMACY PILOT PROGRAM

REGULAR POLICY CHANGE NUMBER:	39
IMPLEMENTATION DATE:	9/2004
ANALYST:	Karen Fairgrieves
FISCAL REFERENCE NUMBER:	1023

	FY 2006-07	FY 2007-08
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$4,178,000	$650,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$4,178,000	$650,000
FEDERAL FUNDS	-$4,178,000	-$650,000

DESCRIPTION

AB 1367 (Chapter 850, Statutes of 2004) required the Department to establish the HIV/AIDS Pharmacy Pilot Program to evaluate the effectiveness of pharmacist care in improving health outcomes for people with HIV/AIDS. AB 1367 provided for an additional dispensing fee of $9.50 to participating pharmacies and was implemented in September 2005, retroactive to September 2004. AB 1367 will sunset on January 1, 2008. The first ten pharmacies to apply that had HIV/AIDS patients representing 90% of their total pharmacy patients in May, June, & July 2004 were allowed to participate. All Medi-Cal prescription drug claims from a participating pharmacy receive the additional $9.50 dispensing fee.

In May 2006, CMS notified the Department that they would not approve a SPA for this program because it is a pilot that requires a waiver for FFP. State law implementing this pilot program was not contingent on federal approval. Therefore, the HIV/AIDS Pharmacy Pilot Program is funded by 100% GF. The Department will reimburse the federal government for the FFP that has been claimed. Payment to the federal government is expected to occur in April 2007.

Assumptions:

1. From September 2004 through June 2006, 561,800 prescriptions were paid the additional $9.50 dispensing fee for a total dispensing fee cost of $5,338,000. The Department will reimburse the federal government $2,669,000 for the FFP collected through June 2006.
2. In July 2006, a pharmacy received a retroactive payment of $418,000 for 44,000 prescriptions that had been dispensed in FY 2005-06.
3. In FY 2006-07, the average monthly prescriptions are 22,800.
4. The average monthly prescriptions for FY 2007-08 are 22,800.
5. The HIV/AIDS Pharmacy Pilot sunsets January 1, 2008.
6. The expenditures for the HIV/AIDS Pharmacy Pilot program are 100% in the base estimate with 50% GF/50% FF funding. This policy change is shifting the funding to 100% GF.

HIV/AIDS PHARMACY PILOT PROGRAM

REGULAR POLICY CHANGE NUMBER: 39

FY 2006-07

Sept 2004 – June 2006 Expenditures		$5,338,000
Retroactive pharmacy payment		$418,000
FY 2006-07 ongoing:	22,800 Rx per month x 12 months x $9.50 =	$2,600,000
Total Funds		$8,356,000
Billed at 50% Federal Funds		* 50%
FFP Reimbursement		**$4,178,000**

FY 2007-08

FY 2007-08	22,800 Rx per month x 6 months x $9.50 =	$1,300,000
Billed at 50% Federal Funds		* 50%
FFP Reimbursement		**$650,000**

NON FFP DRUGS

REGULAR POLICY CHANGE NUMBER:	40
IMPLEMENTATION DATE:	3/2007
ANALYST:	Karen Fairgrieves
FISCAL REFERENCE NUMBER:	108

	FY 2006-07	FY 2007-08
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$2,362,000	$172,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$2,362,000	$172,000
FEDERAL FUNDS	-$2,362,000	-$172,000

DESCRIPTION

Federal Medicaid rules specify that there is no FFP for drugs provided by state Medicaid Programs if the manufacturer of the drug has not signed a rebate contract with the Centers for Medicare and Medicaid Services (CMS).

Effective March 2007, an automated quarterly report is available to determine the costs of drugs for which there is no FFP and the Department will reimburse the federal government for the FFP claimed. The Department will also reimburse the federal government for FFP that was claimed for these drugs since January 1, 2004. This payment is expected to be made in April 2007.

The estimated cost non-FFP drugs from January 1, 2004 to June 30, 2006 is $4,272,000, and the estimated FFP reimbursement of 50% is $2,136,000.

FY 2006-07	**Expenditures**	
FY 2003-04	$ 1,391,000	
FY 2004-05	$ 2,203,000	
FY 2005-06	$ 678,000	
FY 2006-07 Est.	$ 452,000	
	$ 4,724,000	TF
x 50% FFP	**$ 2,362,000**	
FY 2007-08	$ 344,000	TF
x 50% FFP	**$ 172,000**	

DRUG REIMBURSEMENT REDUCTION

REGULAR POLICY CHANGE NUMBER:	41
IMPLEMENTATION DATE:	9/2007
ANALYST:	Karen Fairgrieves
FISCAL REFERENCE NUMBER:	1166

	FY 2006-07	FY 2007-08
FULL YEAR COST - TOTAL FUNDS	$0	-$83,333,000
- STATE FUNDS	$0	-$41,666,500
PAYMENT LAG	1.0000	0.9288
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	-$77,399,700
STATE FUNDS	$0	-$38,699,840
FEDERAL FUNDS	$0	-$38,699,840

DESCRIPTION

Medi-Cal pharmacy reimbursement costs are expected to decrease due to several reimbursement changes that are expected to occur in FY 2007-08.

The federal Deficit Reduction Act of 2005 (DRA) requires CMS to use 250% of the Average Manufacturer Price (AMP) to establish the federal upper limit (FUL) on generic drugs (multiple-source drugs). Although the new FULs are effective January 1, 2007, the federal regulations to standardize a manufacturer calculated AMP have not been issued. CMS has indicated, however, that they will be moving forward with the new FUL of 250% of AMP. The Department anticipates that the new FULs will be lower than the current FULs; however, the extent of the change will not be known until CMS releases the AMP data.

In addition, First Data Bank and the federal government have agreed on a settlement that is expected to reduce AWP for many single-source drugs by approximately 5%. First Data Bank is Medi-Cal's source for the current pricing structure of AWP-17%.

The Department is proposing a broader change to the reimbursement structure which would move all drugs from AWP-17% to an AMP based mark-up in an effort to reduce drug reimbursement costs. Once the federal AMP information is available, the Department will be able to propose a reimbursement structure change.

It is estimated that $100 million TF could be saved annually with the above reimbursement changes. While the implementation of the DRA is estimated to begin September 1, 2007, the savings is dependent upon the release of federal regulations and First Data Bank reducing the reported AWPs.

The Department is conducting a pharmacy rate study to determine if a change in the Medi-Cal pharmacy dispensing fee is necessary. An increase in the dispensing fee would offset some of the savings obtained through the drug cost reductions. Also, a change in the AMP is expected to impact Medi-Cal's rebates collected from drug manufacturers. However, until the AMP is known, the amount of the rebate impact is unknown.

DRUG REIMBURSEMENT REDUCTION

REGULAR POLICY CHANGE NUMBER: 41

		Savings	
Annual Savings		$ 100,000,000	TF
Monthly Savings	/ 12 months	$ 8,333,000	TF
FY 2007-08 Cash Savings	x 10 months	**$ 83,333,000**	TF

MEDICAL SUPPLY CONTRACTING

REGULAR POLICY CHANGE NUMBER:	42
IMPLEMENTATION DATE:	11/2005
ANALYST:	Karen Fairgrieves
FISCAL REFERENCE NUMBER:	1095

	FY 2006-07	FY 2007-08
FULL YEAR COST - TOTAL FUNDS	-$4,123,000	-$8,740,000
- STATE FUNDS	-$2,061,500	-$4,370,000
PAYMENT LAG	0.9799	0.9756
% REFLECTED IN BASE	96.50 %	45.82 %
APPLIED TO BASE		
TOTAL FUNDS	-$141,400	-$4,619,800
STATE FUNDS	-$70,700	-$2,309,890
FEDERAL FUNDS	-$70,700	-$2,309,900

DESCRIPTION

The Department began contracting with medical supply contractors to allow for a change in the Maximum Allowable Product Code (MAPC) from the Average Wholesale Price (AWP) to the Wholesale Selling Price (WSP). This change lowers Medi-Cal's reimbursement rates. The first categories of medical supplies with contracts are catheters, ostomy, wound care, and incontinence.

In FY 2005-06, incontinence briefs and catheters were changed to the WSP reimbursement rate. During FY 2006-07, the remaining listed Medical Supplies were expected to change to WSP for an estimated savings of $7.05 million. Due to unforeseen issues, in product evaluations and in preparation for California's waiver allowing claims processing via UPNs, the finalization of contracts for underpads, pant and pad systems, creams and washes, ostomy, and wound care were delayed. In FY 2007-08, all the listed Medical Supplies will be contracted at the WSP and achieve an annualized savings of $8,740,000.

Medical Supply	**Implementation Date**	**Annual Savings**	**FY 2006-07**	**FY 2007-08**
Incontinence				
Briefs	January 06	$2,201,000	$2,201,000	$2,201,000
Underpads	May 07	$963,000	$161,000	$963,000
Pads/Pants	July 07	$1,676,000	$0	$1,676,000
Creams & Washes	July 07	$1,333,000	$0	$1,333,000
Catheters	November 05	$1,706,000	$1,706,000	$1,706,000
Ostomy	July 07	$200,000	$0	$200,000
Wound Care	June 07	$661,000	$55,000	$661,000
	Total	$8,740,000	**$4,123,000**	**$8,740,000**

ENTERAL NUTRITION PRODUCTS

REGULAR POLICY CHANGE NUMBER: 43
IMPLEMENTATION DATE: 1/2006
ANALYST: Karen Fairgrieves
FISCAL REFERENCE NUMBER: 1091

	FY 2006-07	FY 2007-08
FULL YEAR COST - TOTAL FUNDS	-$3,500,000	-$13,500,000
- STATE FUNDS	-$1,750,000	-$6,750,000
PAYMENT LAG	0.9889	0.9556
% REFLECTED IN BASE	98.60 %	26.84 %
APPLIED TO BASE		
TOTAL FUNDS	-$48,500	-$9,438,100
STATE FUNDS	-$24,230	-$4,719,040
FEDERAL FUNDS	-$24,230	-$4,719,040

DESCRIPTION

Medi-Cal covers enteral nutrition products for beneficiaries who are unable to eat regular food. Medi-Cal spends approximately $65 million dollars a year on enteral nutrition products. In accordance with the Health Trailer Bill of 2002, the Department implemented a rate reduction and has begun contracting with manufacturers for a lower maximum acquisition price.

The negotiation process with manufacturers began in 2002 and was delayed due to legal issues. With these issues resolved, the Department began contracting in January 2006.

The FY 2006-07 savings is estimated to be $3,500,000 and the FY 2007-08 savings is estimated at $13,500,000.

This policy change was formerly a component of the Drug Budget Reduction policy change.

FY 2006-07		**Annualized Savings**		**FY Savings**
Diabetic Enteral formula	12 months x	$ 3,500,000	=	**$ 3,500,000**
FY 2007-08				
Diabetic Enteral formula	12 months x	$ 3,500,000	=	$ 3,500,000
Standard Enteral formula	12 months x	$ 10,000,000	=	$ 10,000,000
				$ 13,500,000

NEW THERAPEUTIC CATEGORY REVIEWS/REBATES

REGULAR POLICY CHANGE NUMBER:	44
IMPLEMENTATION DATE:	8/2005
ANALYST:	Karen Fairgrieves
FISCAL REFERENCE NUMBER:	114

	FY 2006-07	FY 2007-08
FULL YEAR COST - TOTAL FUNDS	-$78,950,000	-$79,700,000
- STATE FUNDS	-$39,475,000	-$39,850,000
PAYMENT LAG	0.9999	1.0000
% REFLECTED IN BASE	99.28 %	98.41 %
APPLIED TO BASE		
TOTAL FUNDS	-$568,400	-$1,267,200
STATE FUNDS	-$284,190	-$633,620
FEDERAL FUNDS	-$284,190	-$633,620

DESCRIPTION

The Budget Act of 2003 included funding to add staff positions to perform new annual drug Therapeutic Category Reviews (TCRs). Drugs are organized into 114 therapeutic categories. The Department regularly conducts TCRs on these drugs to determine safety, efficacy, essential need, potential for misuse, and cost, prior to including drugs in the List of Contract Drugs.

TCRs beginning in FY 2003-04 are 100% in the Medi-Cal Estimate base trends and are no longer included in the Full Year Cost figure above. The total annualized savings for the FY 2003-04 TCRs was estimated at $52,400,000.

The Department had delayed additional TCRs until the impact of Medicare Part D was assessed. In June of 2006, a TCR for Short Acting Beta 2 Agonist Inhalers was implemented. Three TCRs are scheduled for implementation in FY 2007-08. Statin drugs for hypercholesterolemia and cardiac drugs will undergo new reviews due to the introduction of new generic drugs. The Department will, also, conduct a review of antibiotic drugs. With the federal Deficit Reduction Act of 2005 (DRA), the Department is expecting lower pharmacy reimbursement prices (shown in the Drug Reimbursement Reduction policy change). Until the DRA impact is known, savings for the FY 2007-08 TCRs cannot be determined.

Assumptions:

1. Rebate savings will commence seven months after contracts are signed.

NEW THERAPEUTIC CATEGORY REVIEWS/REBATES

REGULAR POLICY CHANGE NUMBER: 44

FY 2003-04		Contract Date	Annual Savings
TCR#1.	HMG-CoA Reductase Inhibitors (Hypercholesterolemia)	7/1/2004	$18,200,000
TCR#2.	Angiotensin Converting Enzyme (ACE) Inhibitors and Angiotensin Receptor blockers (ARB) (cardiac drugs)	7/1/2004	$8,200,000
TCR#3.	Non-sedating Antihistamines	8/1/2004	$15,000,000
TCR#4.	Antidepressants	12/1/2004	$11,000,000
	Annual Savings FY 2003-04 TCRs		$52,400,000[1]

[1] 100% in the base

FY 2004-05			
TCR#1.	Proton Pump Inhibitors	1/1/2005	$66,000,000
TCR#2.	Single Source Non-Steroidal Anti-Inflammatory Drug	3/1/2005	$1,000,000
TCR#3.	Single Source Long Acting Oral Opioid Capsules/Tablets	8/1/2005	$6,800,000
TCR#4.	Ocular Prostaglandin Analogs	9/1/2005	$2,000,000
FY 2005-06			
TCR#1.	Non-Benzodiazepine Sedative Hypnotics	7/1/2005	$2,000,000
TCR#2.	Papain/Urea and Papain/Urea/Chlorophyllin Ointments/Sprays	9/1/2005	$400,000
TCR#3	Short-Acting Beta 2 Agonist Inhalers	6/1/2006[2]	$1,500,000
	Annual Savings FY 2004-05 and FY 2005-06 TCRs		**$79,700,000**

[2] savings began in January 2007

FY 2007-08			
TCR#1.	HMG-CoA Reductase Inhibitors (Hypercholesterolemia)	7/1/2007	Subject to DRA impact
TCR#2.	Angiotensin Converting Enzyme (ACE) Inhibitors and Angiotensin Receptor blockers (ARB) (cardiac drugs)	10/1/2007	
TCR#3	Antibiotics	1/1/2008	

Historical TCR Information

- FY 2003-04 TCR 3 savings is a restriction to generic over-the-counter drugs with a maximum allowable ingredient cost rather than a rebate.

AGED DRUG REBATE RESOLUTION

REGULAR POLICY CHANGE NUMBER:	45
IMPLEMENTATION DATE:	4/2004
ANALYST:	Karen Fairgrieves
FISCAL REFERENCE NUMBER:	43

	FY 2006-07	FY 2007-08
FULL YEAR COST - TOTAL FUNDS	-$6,000,000	-$6,000,000
- STATE FUNDS	-$2,990,800	-$2,990,800
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$6,000,000	-$6,000,000
STATE FUNDS	-$2,990,800	-$2,990,800
FEDERAL FUNDS	-$3,009,200	-$3,009,200

DESCRIPTION

The Legislature approved funding in the Budget Act of 2003 for the Department to add additional staff to resolve aged drug rebate payment disputes.

Between 1991 and 2002 the Medi-Cal program accumulated large rebate disputes with participating drug companies which was cited in an audit of the rebate program by the Office of Inspector General (OIG). The Department estimated $29.5 million of the outstanding balance as being potentially collectable. An approved Budget Change Proposal (BCP) added four staff in FY 2002-03 to resolve these aged disputes and recover additional rebate amounts.

Eleven additional limited term staff were approved for FY 2003-04 to provide a more intensive effort to resolve these disputes. These positions were scheduled to be terminated June 30, 2006. Even though the Department has been successful at collecting a greater amount of aged rebates than originally estimated, an unresolved balance remains. The eleven limited term positions were continued in FY 2006-07 to allow the Department to continue resolving this balance. FY 2005-06 rebate resolutions came from several large manufacturers with several years of unpaid aged rebates, allowing the Department to receive $13 million in aged drug rebate resolutions. The remainder of the aged drug rebates in dispute is from a higher number of drug manufacturers with lower balances. The Department is expecting the resolutions obtained in FY 2006-07 to require more staff time and result in $6 million in additional rebates. Six million dollars of the outstanding aged drug rebates are expected to be collected in FY 2007-08, assuming continuation of the positions through FY 2007-08

	Savings
FY 2003-04:	$ 7,200,000 TF
FY 2004-05:	$16,900,000 TF
FY 2005-06:	$13,000,000 TF
FY 2006-07:	**$ 6,000,000 TF**
FY 2007-08:	**$ 6,000,000 TF**
Total:	$49,100,000 TF

AGED DRUG REBATE RESOLUTION

REGULAR POLICY CHANGE NUMBER: 45

Relevant Historical Rebate Information

- Aged Rebate Disputes from the Drug Budget Reduction policy change are now included as part of the Aged Drug Rebate Resolution.

FAMILY PACT DRUG REBATES

REGULAR POLICY CHANGE NUMBER: 46
IMPLEMENTATION DATE: 12/1999
ANALYST: Karen Fairgrieves
FISCAL REFERENCE NUMBER: 51

	FY 2006-07	FY 2007-08
FULL YEAR COST - TOTAL FUNDS	-$34,033,000	-$34,765,000
- STATE FUNDS	-$13,762,000	-$14,058,200
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$34,033,000	-$34,765,000
STATE FUNDS	-$13,762,000	-$14,058,200
FEDERAL FUNDS	-$20,271,000	-$20,706,800

DESCRIPTION

Rebates for drugs covered through the Family PACT (FPACT) program are obtained by the Department from the drug companies involved. Rebates are estimated by using the actual FFS trend data for drug expenditures, and applying a historical percentage of the actual amounts collected to the trend projection.

Assumptions:

1. 100% State General Fund is applied to 17.79% of the FPACT rebates to account for drugs for undocumented persons in FY 2006-07 and FY 2007-08.

2. Regular FMAP percentage applied to 36.07% of the FPACT rebates to account for the purchase of non-family planning drugs.

3. Family planning percentage (90% FFP) applied to 46.14% of the FPACT rebates.

(Dollars in Thousands) **Fiscal Year**	**FPACT Drug Trends**	**FPACT Rebate**	
FY 2002-03	$82,789	($ 10,956)	Accrual
FY 2003-04	$104,938	($ 26,753)	Cash
FY 2004-05	$107,510	($ 27,581)	Cash
FY 2005-06	$117,417	($ 50,464)	Cash
Est. FY 2006-07		**($ 34,033)**	Cash
Est. FY 2007-08		**($ 34,765)**	Cash

STATE SUPPLEMENTAL DRUG REBATES

REGULAR POLICY CHANGE NUMBER:	47
IMPLEMENTATION DATE:	1/1991
ANALYST:	Karen Fairgrieves
FISCAL REFERENCE NUMBER:	54

	FY 2006-07	FY 2007-08
FULL YEAR COST - TOTAL FUNDS	-$307,565,000	-$316,915,000
- STATE FUNDS	-$153,304,100	-$157,964,300
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$307,565,000	-$316,915,000
STATE FUNDS	-$153,304,100	-$157,964,300
FEDERAL FUNDS	-$154,260,900	-$158,950,700

DESCRIPTION

State supplemental drug rebates for drugs provided through fee-for-service and County Organized Health Systems are negotiated by the Department with drug manufacturers to provide additional drug rebates over and above the federal rebate levels (see the Federal Drug Rebate Policy Change).

Assumptions:

1. Family planning drugs are .389% of rebates and are funded with 90% federal funds and 10% General Funds.

2. Medicare Part D began on January 1, 2006. Medicare assumed drug coverage for dual eligibles, decreasing Medi-Cal's drug purchases and rebates. Due to the rebate lag, the effect on rebates was not seen until FY 2006-07. The reduction in rebates due to the reduction in pharmacy expenditures has been incorporated into the estimated rebates. The impact due to dual eligibles utilizing drugs that have a larger rebate than average is unknown and is being incorporated into the estimate as actual rebate information is available.

3. Disputed Drug Rebates Resolutions had been budgeted in the Federal Drug Rebates, State Supplemental Rebates, and FPACT Rebates policy changes. Disputed Drug Rebate Resolutions is now a separate policy change and the dollars collected are no longer incorporated into the current rebate estimate below.

STATE SUPPLEMENTAL DRUG REBATES

REGULAR POLICY CHANGE NUMBER: 47

(Dollars in Thousands)

Fiscal Year	**FFS Trends**	**Supplemental Rebate**	
FY 2001-02	$3,410,802	($ 331,177)	Accrual
FY 2002-03	$4,063,052	($ 427,485)	Accrual
FY 2003-04	$4,724,915	($ 496,199)	Cash
FY 2004-05	$4,871,742	($ 577,395)	Cash
FY 2005-06	$4,221,100	($ 673,840)	Cash
Est. FY 2006-07		**($ 307,565)**	Cash
Est. FY 2007-08		**($ 316,915)**	Cash

Relevant Historical Rebate Information

- AIDS Healthcare Foundation (as of 1/1/05) and the Health Plan of San Mateo (as of 6/20/05) meet the criteria of a Managed Care Organization (MCO). Under federal law, MCOs cannot participate in the federal Medicaid drug rebate program. These reductions have been incorporated into the estimated rebates.

FEDERAL DRUG REBATE PROGRAM

REGULAR POLICY CHANGE NUMBER:	48
IMPLEMENTATION DATE:	7/1990
ANALYST:	Karen Fairgrieves
FISCAL REFERENCE NUMBER:	55

	FY 2006-07	FY 2007-08
FULL YEAR COST - TOTAL FUNDS	-$647,583,000	-$667,269,000
- STATE FUNDS	-$322,783,900	-$332,596,100
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$647,583,000	-$667,269,000
STATE FUNDS	-$322,783,900	-$332,596,100
FEDERAL FUNDS	-$324,799,100	-$334,672,900

DESCRIPTION

The State Medi-Cal Drug Discount Program and OBRA 1990 allow the Department to obtain price discounts for drugs. Rebates are estimated by using actual FFS trend data for drug expenditures, and applying a historical percentage of actual amounts collected to the trend projection.

Assumptions:

1. Family planning drugs are .389% of rebates and are funded with 90% federal funds and 10% General Funds.

2. Medicare Part D began on January 1, 2006. Medicare assumed drug coverage for dual eligibles, decreasing Medi-Cal's drug purchases and rebates. Due to the rebate lag, the effect on rebates was not seen until FY 2006-07. The reduction in rebates due to the reduction in pharmacy expenditures has been incorporated into the estimated rebates. The impact due to dual eligibles utilizing drugs that have a larger rebate than average is unknown and is being incorporated into the estimate as actual rebate information is available.

3. Disputed Drug Rebates Resolutions had been budgeted in the Federal Drug Rebates, State Supplemental Rebates, and FPACT Rebates policy changes. Disputed Drug Rebate Resolutions is now a separate policy change and the dollars collected are no longer incorporated into the current rebate estimate below.

FEDERAL DRUG REBATE PROGRAM

REGULAR POLICY CHANGE NUMBER: 48

(Dollars in Thousands) **Fiscal Year**	**FFS Trends**	**Federal Rebate**	
FY 2002-03	$4,063,052	($866,227)	Accrual
FY 2003-04	$4,724,915	($973,512)	Cash
FY 2004-05	$4,871,742	($1,389,294)	Cash
FY 2005-06	$4,211,100	($1,446,858)	Cash
Est. FY 2006-07		**($647,583)**	Cash
Est. FY 2007-08		**($667,269)**	Cash

Relevant Historical Rebate Information

- AIDS Healthcare Foundation (as of 1/1/05) and the Health Plan of San Mateo (as of 6/20/05) meet the criteria of a Managed Care Organization (MCO). Under federal law, MCOs cannot participate in the federal Medicaid drug rebate program. These reductions have been incorporated into the estimated rebates.

MANAGED CARE INTERGOVERNMENTAL TRANSFERS

REGULAR POLICY CHANGE NUMBER:	52
IMPLEMENTATION DATE:	7/2005
ANALYST:	Shelley Stankeivicz
FISCAL REFERENCE NUMBER:	1054

	FY 2006-07	FY 2007-08
FULL YEAR COST - TOTAL FUNDS	$150,933,000	$199,911,000
- STATE FUNDS	$75,461,500	$99,955,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$150,933,000	$199,911,000
STATE FUNDS	$75,461,500	$99,955,500
FEDERAL FUNDS	$75,471,500	$99,955,500

DESCRIPTION

SAN MATEO

The County of San Mateo transfers funds to the Department for the purpose of providing capitation rate increases to the Health Plan of San Mateo (HPSM). The IGT rate increase and the related Quality Improvement Assurance Fee (QIF) rate increase are included in the capitation rates for HPSM. This policy change includes only the IGT, which reimburses the GF cost of the IGT rate increase.

The transfer of funds from San Mateo County began in February 2006 and was retroactive to July 2005.

LOS ANGELES

The County of Los Angeles will transfer funds to the Department for the purpose of providing capitation rate increases to the Two Plan Model plans in Los Angeles County. These funds will be used for the nonfederal share of capitation rate increases. The total IGT for Los Angeles County is $178,700,000, which does not include the QIF rate increase related to the IGT. Currently, neither the IGT nor the related QIF rate increase are included in the capitation rates for Los Angeles County. Therefore, they are included in this policy change. The QIF rate increase is funded 50% General Fund and 50% Federal Financial Participation. The revenue to the State General Fund from the QIF is not included in the Medi-Cal program budget.

The transfer of funds from Los Angeles County will begin in June 2007 and will be retroactive to October 1, 2006.

MANAGED CARE INTERGOVERNMENTAL TRANSFERS

REGULAR POLICY CHANGE NUMBER: 52

	FY 2006-07			
(Dollars in Thousands)	**Total**	**FFP**	**GF**	**Reimb.**
San Mateo IGT	$4,000			$4,000
Los Angeles IGT	$134,100	$67,050		$67,050
Los Angeles IGT/QIF Rate Increase	$12,833	$6,417	$6,417	
Total Los Angeles	$146,933	$73,467	$6,417	$71,050
Total Los Angeles and San Mateo	**$150,933**	**$73,467**	**$6,417**	**$75,050**
Revenue to State GF for Los Angeles QIF (Not Included in CDHS Budget)			($8,000)	

	FY 2007-08			
(Dollars in Thousands)	**Total**	**FFP**	**GF**	**Reimb.**
San Mateo IGT	$4,000			$4,000
Los Angeles IGT	$178,800	$89,400		$89,400
Los Angeles IGT/QIF Rate Increase	$17,111	$8,556	$8,556	
Total Los Angeles	$195,911	$97,956	$8,556	$89,400
Total Los Angeles and San Mateo	**$199,911**	**$97,956**	**$8,556**	**$93,400**
Revenue to State GF for Los Angeles QIF (Not Included in CDHS Budget)			($11,000)	

The reimbursements from San Mateo and Los Angeles Counties are paid from Item 4260-610-0995.

RISK PAYMENTS FOR MANAGED CARE PLANS

REGULAR POLICY CHANGE NUMBER:	59
IMPLEMENTATION DATE:	7/2000
ANALYST:	Shelley Stankeivicz
FISCAL REFERENCE NUMBER:	65

	FY 2006-07	FY 2007-08
FULL YEAR COST - TOTAL FUNDS	$4,000,000	$4,500,000
- STATE FUNDS	$2,000,000	$2,250,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$4,000,000	$4,500,000
STATE FUNDS	$2,000,000	$2,250,000
FEDERAL FUNDS	$2,000,000	$2,250,000

DESCRIPTION

County Organized Health Systems and the Two-Plan Model Medi-Cal managed care health care plans have the option of receiving rates with reinsurance. Reinsurance payments are made to participating plans when an individual beneficiary's cost exceeds a specified amount. Plans selecting reinsurance protection receive slightly lower monthly capitation rates.

Currently, the only plan which participates in reinsurance is Santa Barbara Regional Health Initiative.

FFS COSTS FOR MANAGED CARE ENROLLEES

REGULAR POLICY CHANGE NUMBER:	64
IMPLEMENTATION DATE:	7/2005
ANALYST:	Shelley Stankeivicz
FISCAL REFERENCE NUMBER:	1082

	FY 2006-07	FY 2007-08
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$0

DESCRIPTION

This is an informational policy change displaying the Medi-Cal fee-for-service (FFS) expenditures for Medi-Cal managed care plan enrollees. FFS expenditures occur for managed care enrollees for covered Medi-Cal services excluded by the health plan contract. In FY 2005-06 FFS payments for managed care enrollees totaled:

Expenditures by Aid Category

	Other	CCS/GHPP	Total
Families	$155,686,000	$285,912,000	$441,598,000
Disabled	173,952,000	161,317,000	335,269,000
Aged	81,779,000	21,000	81,800,000
200% Poverty	3,149,000	18,281,000	21,430,000
MI Child	2,732,000	11,053,000	13,785,000
133% Poverty	4,212,000	7,328,000	11,540,000
Other	6,894,000	40,000	6,934,000
100% Poverty	1,836,000	6,626,000	8,462,000
Blind	2,502,000	3,415,000	5,917,000
MI Adult	3,741,000	817,000	4,558,000
Total	$436,483,000	$494,810,000	$931,293,000

NF-B RATE CHANGES AND QA FEE

REGULAR POLICY CHANGE NUMBER:	65
IMPLEMENTATION DATE:	8/2005
ANALYST:	Robert Ducay
FISCAL REFERENCE NUMBER:	1021

	FY 2006-07	FY 2007-08
FULL YEAR COST - TOTAL FUNDS	$139,748,000	$325,113,000
- STATE FUNDS	$69,874,000	$162,556,500
PAYMENT LAG	0.8734	0.9328
% REFLECTED IN BASE	100.00 %	50.27 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$150,813,900
STATE FUNDS	$0	$75,406,940
FEDERAL FUNDS	$0	$75,406,940

DESCRIPTION

AB 1629 (Chapter 875, Statutes of 2004) required the Department to provide a cost of living adjustment (COLA), implement a facility-specific rate methodology, and impose a quality assurance (QA) fee for freestanding skilled nursing facilities (NF-Bs), including adult subacute days and excluding pediatric subacute and rural swing days. The QA fee and rate methodology sunset on July 31, 2008. The State General Fund and the NF-Bs will share in the increased FFP generated by the QA fee. The State Plan Amendment was approved in September 2005. The August 2004 COLA and the 3% QA Fee rate increase were implemented October 2005 and March 2006, respectively. The August 2005 rate methodology change, with growth capped at 8%, and an increase to a 6% QA Fee rate increase were implemented in April 2006. These costs have been incorporated into the base trend.

Assumptions:

1. The QA fee is expected to generate $116 million SGF for FY 2004-05, $235 million SGF for FY 2005-06, and $248 million for FY 2006-07 on an accrual basis.

2. Only the cost of the rate increase and the QA fee rate increase are reflected in the Medi-Cal budget.

3. The FY 2006-07 rate increase, capped at 5% growth, was implemented in October 2006, retroactive to August 1, 2006. FY 2006-07 will have eleven months of the FFS rate increase and its impact is estimated to be $139,748,000. A full year impact is estimated to be $152,452,000.

4. The FY 2007-08 rate increase will be capped at 5.5% growth, and will be effective August 1, 2007. The QA fee currently at 6% will be reduced to 5.5% effective January 1, 2008. Rates will be adjusted to reflect the lower maximum QA fee. FY 2007-08 will have eleven months of the FFS rate increase and its impact is estimated to be $172,661,000.

NF-B RATE CHANGES AND QA FEE

REGULAR POLICY CHANGE NUMBER: 65

5. AB 1835 (Chapter 230, Statutes of 2006) increases the California minimum wage from $6.75 to $7.50 on January 1, 2007, and to $8.00 on January 1, 2008. Pursuant to State Plan Amendment 4.19-C, Medi-Cal rates for long term care (LTC) facilities are required to be adjusted for the minimum wage increase using a computed "add-on". The 2007-08 rate will include funding for both the wage increase retroactive to January 2007 and the wage increase effective January 1, 2008. Both increases will be implemented through the rate change effective in August 2007.

6. The FY 2006-07 rate increase impact on Managed Care rates is estimated to be $26,326,000 in FY 2006-07 and $28,719,000 in FY 2007-08. The FY 2007-08 rate increase impact on Managed Care rates is estimated to be $28,294,000 in FY 2007-08. Managed Care costs are not included in this policy change. They are included in each applicable managed care plan's policy change.

Fee-For-Service	**FY 2006-07**	**FY 2007-08**
August 2006 Rate Increase	$131,363,000	$143,305,000
August 2006 QAF Increase	$ 8,385,000	$ 9,147,000
August 2007 Rate Increase		$165,944,000
August 2007 QAF Increase		$ 1,624,000
Minimum Wage Increase (Jan. 1, 2007 and Jan. 1, 2008)		$ 5,093,000
Total FFS Cost	**$139,748,000**	**$325,113,000**

LTC RATE ADJUSTMENT

REGULAR POLICY CHANGE NUMBER:	66
IMPLEMENTATION DATE:	8/2006
ANALYST:	Robert Ducay
FISCAL REFERENCE NUMBER:	1046

	FY 2006-07	FY 2007-08
FULL YEAR COST - TOTAL FUNDS	$58,944,000	$129,215,000
- STATE FUNDS	$29,472,000	$64,607,500
PAYMENT LAG	0.8730	0.9364
% REFLECTED IN BASE	100.00 %	53.14 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$56,699,200
STATE FUNDS	$0	$28,349,580
FEDERAL FUNDS	$0	$28,349,580

DESCRIPTION

The LTC rate adjustment includes Nursing Facility-As (NF-A), Distinct Part Nursing Facility-Bs (DP/NF-Bs), Rural Swing Beds, Distinct Part Subacute, Pediatric Subacute, and ICF-DD facilities. The NF-B rate increase is defined by AB 1629 (Chapter 875, Statutes of 2004) and is included in the SNF Rate Changes and QA Fee policy change.

Assumptions:

1. The cumulative weighted increase for NF-As, DP/NF-Bs, Rural Swing Beds, Distinct Part Subacute, and Pediatric Subacutes was 7.86% in FY 2006-07. The estimated FY 2007-08 increase for these facilities is 8.04%

2. For ICF-DDs, including Habilitative and Nursing, the cumulative weighted increase was 2.02% in FY 2006-07. The estimated FY 2007-08 increase for these facilities is 2.36%.

3. FY 2006-07 rate increases were effective August 2006. FY 2007-08 rate increases will be effective August 2007.

4. AB 1835 (Chapter 230, Statutes of 2006) increases the California minimum wage from $6.75 to $7.50 on January 1, 2007, and to $8.00 on January 1, 2008. Pursuant to State Plan Amendment 4.19-C, Medi-Cal rates for long term care (LTC) facilities are required to be adjusted for the minimum wage increase using a computed “add-on”. The 2007-08 rate will include funding for both the wage increase retroactive to January 2007 and the wage increase effective January 1, 2008. Both increases will be implemented through the rate change effective in August 2007.

5. The managed care costs for LTC rate increases for FY 2006-07 are estimated to be $8,535,826. The FY 2007-08 costs are estimated to be $9,173,905. Managed care costs are not included in this policy change. They are included in each applicable managed care plan’s policy change.

LTC RATE ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 66

Annual Rate Increase	FY 2006-07	FY 2007-08
FFS ICF-DDs:	$9,138,000	$9,461,000
FFS other LTC:	$55,165,000	$60,089,000
Minimum Wage Increase		$1,264,000
Annual FFS:	$64,302,000	$70,814,000
	*11/12 Year	* 11/12 Year
FY Increase:	$58,944,000	$64,913,000
Managed Care:	(See Plans)	(See Plans)
FY Cost:	**$58,944,000 TF**	$64,913,000
FY 2006-07		
Annual Increase:		$64,302,000
FY FFS Cost:		**$129,215,000 TF**

ANNUAL MEI INCREASE FOR FQHCS/RHCS

REGULAR POLICY CHANGE NUMBER:	67
IMPLEMENTATION DATE:	10/2005
ANALYST:	Robert Ducay
FISCAL REFERENCE NUMBER:	88

	FY 2006-07	FY 2007-08
FULL YEAR COST - TOTAL FUNDS	$21,453,000	$46,802,000
- STATE FUNDS	$10,726,500	$23,401,000
PAYMENT LAG	0.7870	0.9208
% REFLECTED IN BASE	62.18 %	30.47 %
APPLIED TO BASE		
TOTAL FUNDS	$6,385,300	$29,964,100
STATE FUNDS	$3,192,670	$14,982,070
FEDERAL FUNDS	$3,192,670	$14,982,080

DESCRIPTION

This Policy Change budgets the annual Medicare Economic Index (MEI) increase for all federally qualified health centers (FQHCs) and rural health clinics (RHCs) under the prospective payment system (PPS) reimbursement methodology. The annual ongoing MEI increases will be applied each October.

Assumptions:

1. FY 2005-06 FQHC/RHC expenditures were $871,383,000 and average monthly expenditures were $72,615,000. Estimated annual expenditures for FY 2006-07 are $993,412,000 and expenditures without the MEI increase are estimated to be $971,959,000. Estimated annual expenditures for FY 2007-08 are $1,116,553,000 and estimated expenditures without the MEI are $1,069,751,000.

2. Utilization increases 10.06% per year.

3. The MEI increase effective October 1, 2006 was 2.8%.

4. The MEI increase effective October 1, 2007 will be 2.1%.

5. For FY 2006-07 an increase of $1,564,000 per month is assumed on top of the average monthly expenditures for FY 2005-06 starting in July 2006. 2.8% of each month's expenditures starting in October 2006 and ending in June 2007 are summed to find the MEI impact in FY 2006-07.

6. For FY 2007-08 MEI impacts are removed from total estimated expenditures in FY 2006-07 and expenditures are increased by the estimated annual utilization. An annualized 2.8% MEI for the October 2006 increase and nine months of the October 2007 increase are summed totaling the MEI impact in FY 2007-08.

ANNUAL MEI INCREASE FOR FQHCS/RHCS

REGULAR POLICY CHANGE NUMBER: 67

FY	**2006-07:**	
	2006 Increase:	**$21,453,000**
FY	**2007-08:**	
	2006 Increase:	$29,953,000
	2007 Increase:	$16,849,000
		$46,802,000

NON-CONTRACT HOSP. 10% INTERIM RATE RED.

REGULAR POLICY CHANGE NUMBER:	68
IMPLEMENTATION DATE:	9/2004
ANALYST:	Robert Ducay
FISCAL REFERENCE NUMBER:	178

	FY 2006-07	FY 2007-08
FULL YEAR COST - TOTAL FUNDS	$7,026,000	$38,124,000
- STATE FUNDS	$3,513,000	$19,062,000
PAYMENT LAG	0.8550	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$6,007,200	$38,124,000
STATE FUNDS	$3,003,620	$19,062,000
FEDERAL FUNDS	$3,003,620	$19,062,000

DESCRIPTION

The interim rate of payment for non-contract hospital inpatient services is calculated to approximate the reimbursable cost to the hospitals for providing services to Medi-Cal beneficiaries. The interim payment provides payments for services provided through the hospitals' fiscal year. Costs are then reconciled using hospital cost reports filed within five months of a hospital's fiscal year end. If the cost of providing services is greater than the interim payment, the hospital is reimbursed the difference. If costs are lower, the hospital must reimburse the difference to Medi-Cal.

The Health Trailer Bill of 2004 reduced non-contract interim hospital payments for acute inpatient services by 10%, effective September 1, 2004, for claims with dates of service after July 1, 2004. The Trailer Bill also specified that the reconciliation for this period will be the lesser of the hospital's audited cost per day for FY 2004-05 or the audited cost per day for FY 2003-04.

This was a one-year rate reduction for which savings will normally occur over three fiscal years and is 100% reflected in the base trends. This policy change reflects the changes in payments based on audited cost settlements normally incorporated into the base estimate. Recent auditing trends indicated the savings occurred over a three year period with the first year of impact occurring two fiscal years following the fiscal year being addressed. Therefore, the same is assumed for these audits, which began in FY 2006-07, two years after the production year, and will be completed in FY 2008-09 with a savings generated over a three year period.

$561,482,000	Non-contract hospital interim payments for FY 2004-05		
- $ 1,231,000	Claims paid prior to Sept 2004		
- $28,715,000	Administrative Days		
$531,536,000	x 10% =	$53,154,000	($26,577,000 GF)

FY 2006-07:	$53,154,000	x 13.22% =	**$7,026,000**
FY 2007-08:	$53,154,000	x 71.72% =	**$38,124,000**
FY 2008-09:	$53,154,000	x 15.06% =	$8,003,648

DME REIMBURSEMENT CHANGES

REGULAR POLICY CHANGE NUMBER: 69
IMPLEMENTATION DATE: 9/2006
ANALYST: Robert Ducay
FISCAL REFERENCE NUMBER: 1123

	FY 2006-07	FY 2007-08
FULL YEAR COST - TOTAL FUNDS	$1,977,000	$5,224,000
- STATE FUNDS	$988,500	$2,612,000
PAYMENT LAG	0.7085	0.8580
% REFLECTED IN BASE	32.15 %	4.96 %
APPLIED TO BASE		
TOTAL FUNDS	$950,400	$4,259,900
STATE FUNDS	$475,190	$2,129,940
FEDERAL FUNDS	$475,190	$2,129,940

DESCRIPTION

The Health Budget Trailer Bill of 2006 made the following changes to the reimbursement methodology for certain durable medical equipment (DME) items (custom wheelchairs, custom rehabilitation equipment, and oxygen):

1. Effective September 1, 2006, for DME with no specified maximum rate, it adds the option of paying the manufacturer's suggested retail price published prior to June 1, 2006, documented by a printed catalog or hard copy of an electronic catalog page showing the price on that date, reduced by a percentage discount not to exceed 20%.

2. Effective September 1, 2006, for custom wheelchairs and accessories, it adds the option of paying the manufacturer's suggested retail price published prior to June 1, 2006, documented by a printed catalog or hard copy of an electronic catalog page showing the price on that date, reduced by a percentage discount not to exceed 15%, if the provider employs or contracts with a qualified rehabilitation professional.

3. Effective January 1, 2007, for oxygen delivery systems and contents, it utilizes national Healthcare Common Procedure Coding System (HCPCS) codes to establish reimbursement which will be the lesser of (a) the amount billed as specified in Section 51008.1 of Title 22 of the California Code of Regulations, (b) an amount not to exceed 80% of the Medicare rate, or (c) the guaranteed acquisition cost negotiated by contract, plus a percentage markup established by the Department. This rate is currently $246.11.

4. Medicare’s oxygen policy allows beneficiaries to bill once a month for oxygen delivery systems and contents. However, the Medi-Cal population includes more active individuals who work, go to school, and participate in many other activities. Because this population’s oxygen usage is greater, beginning July 1, 2007, retroactive to January 1, 2007, the Department will change the oxygen policy to allow beneficiaries to bill for additional oxygen each month at a rate of $16.87. Retroactive payments will be made in FY 2007-08.

DME REIMBURSEMENT CHANGES

REGULAR POLICY CHANGE NUMBER: 69

The estimated costs are:

	FY 2006-07	FY 2007-08	Annualized Ongoing
DME	$298,000	$358,000	$358,000
Wheelchairs & wheelchair accessories	$25,000	$30,000	$30,000
Oxygen delivery system and contents	$1,654,000	$4,496,000	$6,589,000
FY 2006-07 Additional Oxygen Retro		$340,000	
Total	**$1,977,000**	**$5,224,000**	$6,977,000

HOSPICE RATE INCREASES

REGULAR POLICY CHANGE NUMBER:	70
IMPLEMENTATION DATE:	10/2006
ANALYST:	Robert Ducay
FISCAL REFERENCE NUMBER:	96

	FY 2006-07	FY 2007-08
FULL YEAR COST - TOTAL FUNDS	$6,156,000	$12,128,000
- STATE FUNDS	$3,078,000	$6,064,000
PAYMENT LAG	0.8164	0.8977
% REFLECTED IN BASE	65.00 %	30.05 %
APPLIED TO BASE		
TOTAL FUNDS	$1,759,000	$7,615,700
STATE FUNDS	$879,510	$3,807,840
FEDERAL FUNDS	$879,510	$3,807,840

DESCRIPTION

1. **Hospice Services**
   Pursuant to state regulations, Medi-Cal hospice service rates are established in accordance with Section 1902 (a)(13), (42 USC 1396 a(a)(13)) of the federal Social Security Act. This act requires annual increases in payment rates for hospice care services based on corresponding Medicare rates. Total expenditures for hospice services in FY 2005-06 were $49,905,000. This policy change budgets the rate increases that were effective October 1, 2006 and estimates the increases for FY 2007-08. The estimated weighted increase for hospice service rates is 2.79% in FY 2006-07 and 3.47% for FY 2007-08.

2. **Hospice Room and Board**
   Hospice room and board rates had been set at 95% of the weighted statewide average rate for NF-As and NF-Bs. In February 2003, the Department changed the methodology to tie each hospice facility's room and board rate to 95% of the individual facility's affiliated nursing facility rate and included ICF/DDs, ICF/DD-Hs, & ICF/DD-Ns. This was done to comply with the CMS Medicaid Manual requirements. This policy change assumes hospice room and board rates were increased with the adoption of AB 1629 and its related State Plan Amendments. Total expenditures for hospice room and board for FY 2005-06 were $84,696,000. In August 2006, the AB 1629 facilities received a rate increase capped at 5%. In August 2007, the AB 1629 facilities will receive a rate increase capped at a 5.5% growth rate. A reduction in this cap to 4.5% for FY 2007-08 is budgeted in a separate policy change. The potential impact to hospice rates has been included in that policy change.

	FY 2006-07		**FY 2007-08**	
FY 2006-07 Hospice Services :	$1,237,000	TF	$1,649,000	TF
FY 2006-07 Room & Board :	$4,919,000	TF	$4,025,000	TF
FY 2007-08 Hospice Services :			$1,619,000	TF
FY 2007-08 Room & Board :			$4,835,000	TF
Total :	**$6,156,000**	TF	**$12,128,000**	TF

NF/AH (NF A/B LOC) WAIVER CAP INCREASE

REGULAR POLICY CHANGE NUMBER: 72
IMPLEMENTATION DATE: 7/2007
ANALYST: Julie Chan
FISCAL REFERENCE NUMBER: 1132

	FY 2006-07	FY 2007-08
FULL YEAR COST - TOTAL FUNDS	$0	$7,343,000
- STATE FUNDS	$0	$3,671,500
PAYMENT LAG	1.0000	0.8252
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$6,059,400
STATE FUNDS	$0	$3,029,720
FEDERAL FUNDS	$0	$3,029,720

DESCRIPTION

In response to the increased cost of nursing level care and enactment of nursing facility rate increases, the Department will increase the annual individual waiver program budget for beneficiaries on the Nursing Facility/Acute Hospital (NF/AH) Waiver at the NF A and NF B levels of care (LOC) effective July 1, 2007. The budget cap for beneficiaries at the NF A LOC will increase from $24,551 to $29,548, and the cap for beneficiaries at the NF B LOC will increase from $35,948 to $48,180. This increase will allow beneficiaries to absorb recent increases in IHSS and Waiver Personal Care Services rates so they may continue to receive safe and appropriate home care in lieu of long-term institutional placement.

Assumptions:

1. The Department estimates there are 18 NF A level beneficiaries and 445 NF B level beneficiaries. On January 1, 2007, 55 NF Level B beneficiaries were transitioned into the IHO Waiver, leaving 390 beneficiaries currently at the NF B LOC.

2. Beginning in May 2007, it is anticipated that 213 additional beneficiaries currently on a waiting list will be phased into existing slots of the NF/AH Waiver at a rate of approximately 28 per month for 8 months. One month of lag is assumed for the costs of the new beneficiaries.

3. All 213 on the waiting list are assumed to be enrolled by December 2007.

4. Average monthly enrollees impacted by the new cap will be 591 in FY 2007-08.

NF/AH (NF A/B LOC) WAIVER CAP INCREASE

REGULAR POLICY CHANGE NUMBER: 72

Estimated 2007-08 Cases

Level of Care	Estimated Annual Cases	Current Annual Budget	Proposed Annual Budget	Proposed Annual Increase	Annual Cost
Level A	18	$24,551	$29,548	$ 4,997	$90,000
Level B	603	$35,948	$48,180	$12,232	$7,376,000
Total					$7,466,000

Level of Care	FY 2007-08 TF	GF
Level A	$90,000	$45,000
Level B	$7,253,000	$3,626,000
Total	**$7,343,000**	**$3,671,000**

NF-B 2007-08 RATE CAP ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 73
IMPLEMENTATION DATE: 8/2007
ANALYST: Robert Ducay
FISCAL REFERENCE NUMBER: 1165

	FY 2006-07	FY 2007-08
FULL YEAR COST - TOTAL FUNDS	$0	-$37,371,000
- STATE FUNDS	$0	-$18,685,500
PAYMENT LAG	1.0000	0.8724
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	-$32,602,500
STATE FUNDS	$0	-$16,301,230
FEDERAL FUNDS	$0	-$16,301,230

DESCRIPTION

The Department is proposing legislation to reduce the growth cap for freestanding skilled nursing facilities (NF-Bs) and freestanding adult subacute facilities. AB 1629 (Chapter 875, Statutes of 2004) limited the growth rate for the facilities' Medi-Cal rate to 5.5% for the rate year beginning August 1, 2007. The proposed legislation will change the cap to 4.5% for the rate year beginning August 1, 2007.

Reducing the growth cap to 4.5% will result in a fee-for-service savings of $32,651,000 TF ($16,325,500 GF) in FY 2007-08. This is an adjustment to the NF-B Rate Changes and QA Fee policy change which shows the fiscal impact of AB 1629 with the FY 2007-08 growth cap at 5.5%. This is also an adjustment to the Hospice Rates policy change. Since hospice room and board rates are set at 95% of the individual facility's affiliated nursing facility rate, those hospices affiliated with AB 1629 nursing facilities will also be affected by a reduction in the growth cap. Reducing the growth cap to 4.5% for AB 1629 facilities will also result in a decrease in Managed Care costs. These savings are also reflected in this policy change.

NF-B 2007-08 RATE CAP ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 73

FY 2007-08	**TF**
AB 1629 Expenditures at 5.5% Growth	$ 3,679,088,000
AB 1629 Expenditures at 4.5% Growth	$ 3,644,268,000
AB 1629 Annualized Savings	$ -34,819,000
Months of Implementation	x 11/12
FY 2007-08 AB 1629 Estimated Total Savings	$ -31,918,000
AB 1629 Hospice Expenditures at 5.5% Growth	$ 88,515,000
AB 1629 Hospice Expenditures at 4.5% Growth	$ 87,716,000
AB 1629 Hospice Room and Board Annualized Savings	$ -799,000
Months of Implementation	x11/12
FY 2007-08 AB 1629 Hospice Estimated Total Savings	$ -733,000
AB 1629 Managed Care Expenditures at 5.5% Growth	$ 28,294,000
AB 1629 Managed Care Expenditures at 4.5% Growth	$ 23,145,000
AB 1629 Managed Care Annualized Savings	$ - 5,149,000
Months of Implementation	x11/12
FY 2007-08 AB 1629 Managed Care Total Savings	$ - 4,720,000
Hospice Room and Board Savings + AB 1629 Savings =	**$ -37,371,000**

HOSP FINANCING - DSH PMT

REGULAR POLICY CHANGE NUMBER:	74
IMPLEMENTATION DATE:	7/2005
ANALYST:	Karen Fairgrieves
FISCAL REFERENCE NUMBER:	1073

	FY 2006-07	FY 2007-08
FULL YEAR COST - TOTAL FUNDS	$1,612,796,000	$1,614,917,000
- STATE FUNDS	$580,733,000	$582,337,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,612,796,000	$1,614,917,000
STATE FUNDS	$580,733,000	$582,337,500
FEDERAL FUNDS	$1,032,063,000	$1,032,579,500

DESCRIPTION

Effective July 1, 2005, based on SPA 05-022, the federal Disproportionate Share Hospital (DSH) allotment is available for uncompensated Medi-Cal and uninsured costs incurred by Disproportionate Share Hospitals (DSH).

- Designated Public Hospitals (DPHs) will receive their allocation of federal DSH payments from the Demonstration DSH Fund based on the hospitals' certified public expenditures (CPEs), up to 100 percent of uncompensated Medi-Cal and uninsured costs. DPHs may also receive allocations of federal and nonfederal DSH funds through intergovernmental transfer-funded payments for expenditures above 100 percent of costs, up to 175 percent of the hospitals' uncompensated Medi-Cal and uninsured costs.
- Nondesignated Public Hospitals (NDPHs) will receive their allocation from the federal DSH allotment and State General Fund based on hospitals' uncompensated Medi-Cal and uninsured costs up to the OBRA limits.
- Private DSH hospitals, under the Special Terms and Conditions, should be allocated a total of $160.00 from the federal DSH allotment and State General Fund each demonstration year. All DSH eligible Private hospitals will receive a pro-rata share of the $160.00.

The California DSH federal allotment for Fiscal Years 2005-06 through 2009-10 is $1,032,580,000. The General Fund (GF) reflected in this policy change is paid from Item 4260-101-0001, the FFP from Item 4260-601-7502 or 4260-101-0890, and the IGTs from Item 4260-606-0834. It is assumed that the DSH payments will be made as follows on a cash basis:

HOSP FINANCING - DSH PMT

REGULAR POLICY CHANGE NUMBER: 74

FY 2006-07	TF	GF	FF	IGT
DSH 2005-06	$ 131,755,000	$ 1,990,000	$ 85,369,000	$ 44,395,000
DSH 2006-07	$ 1,481,041,000	$ 8,285,000	$ 946,693,000	$ 526,063,000
	$ 1,612,796,000	**$ 10,275,000**	**$ 1,032,062,000**	**$ 570,458,000**
FY 2007-08				
DSH 2006-07	$ 133,876,000	$ 749,000	$ 85,887,000	$ 47,240,000
DSH 2007-08	$ 1,481,041,000	$ 8,285,000	$ 946,693,000	$ 526,063,000
	$ 1,614,917,000	**$ 9,034,000**	**$ 1,032,580,000**	**$ 573,303,000**

SB 1100 requires an interim reconciliation of DSH payments. Each Designated Public Hospital's (DPH's) 2005-06 interim Disproportionate Share Hospital (DSH) payments will be reconciled to its filed Medi-Cal 2552-96 cost report for the fiscal year ending June 30, 2006.

The interim reconciliation process and payments for Demonstration Year 1 will occur in June 2007 and may result in an overpayment or underpayment to a DPH, which will be handled as follows:

- For DPHs that have been determined to be overpaid, the Department will recoup any overpayments.
- For DPHs that have been determined to be underpaid, the Department will make a payment equal to the difference between the DSH payments that the DPHs have received and the DSH payments estimated in the interim reconciliation process.

The interim reconciliation process for Demonstration Years 2-5 will occur each year in April of the ensuing year. It is expected that any distributions to those DPHs who were underpaid will be made in the same fiscal year as the overpayments are recouped.

HOSP FINANCING - SAFETY NET CARE POOL

REGULAR POLICY CHANGE NUMBER:	75
IMPLEMENTATION DATE:	9/2005
ANALYST:	Karen Fairgrieves
FISCAL REFERENCE NUMBER:	1072

	FY 2006-07	FY 2007-08
FULL YEAR COST - TOTAL FUNDS	$594,266,000	$578,427,000
- STATE FUNDS	$0	$31,652,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$594,266,000	$578,427,000
STATE FUNDS	$0	$31,652,000
FEDERAL FUNDS	$594,266,000	$546,775,000

DESCRIPTION

Effective July 1, 2005, based on the Special Terms and Conditions (STC) of the Medi-Cal Hospital/Uninsured Care Demonstration (MH/UCD), a Safety Net Care Pool (SNCP) was established to support the provision of services to the uninsured. The SNCP makes available $586 million in federal matching dollars per Demonstration Year for baseline and stabilization funding and an additional $180 million per Demonstration Year, if the Department meets a specified timeline for implementing a healthcare coverage initiative during the last three years of the MH/UCD. The SNCP is to be distributed through the CPEs of DPHs for uncompensated care to the uninsured and the federalizing of four state-funded health care programs. The four state-funded health care programs are the Genetically Handicapped Persons Program (GHPP), California Children Services (CCS), Medically Indigent Adult Long-Term Care (MIA LTC), and Breast and Cervical Cancer Treatment Program. The Safety Net Care Pool funding for these programs are in separate policy changes in the Medi-Cal Estimate.

In FY 2005-06, $400,519,000 FFP in SNCP funding was distributed to DPHs through the use of CPEs for Demonstration Year 2005-06. The Department expects DPHs will require a total of $537,000,000 from the SNCP for Demonstration Year 2005-06. The Department used $80,753,000 FFP from the FY 2005-06 SNCP funding to CPE the four state-only programs, leaving $505,248,000 FFP available in the SNCP for the DPHs. In order to fully fund the DPHs under the requirements of SB 1100, the Department will utilize the $31,652,000 of GF that was made available from using FFP for the state-only programs.

HOSP FINANCING - SAFETY NET CARE POOL

REGULAR POLICY CHANGE NUMBER: 75

(Dollars in Thousands)

	Accrual		Cash		
Demonstration FY	**State-Only Funded Programs**	**Due to DPHs**	**FY 2005-06**	**FY 2006-07**	**FY 2007-08**
FY 2005-06	$80,753	$505,248	$400,519	$100,381	$4,348
GF to DPHs		$31,652			$31,652
FY 2005-06 Total	$80,753	$536,900	$400,519	$100,381	$36,000
FY 2006-07	$44,450	$541,550		$493,885	$47,665
FY 2007-08	$46,260	$539,740			$494,762
Expenditures			$400,519	**$594,266**	**$578,427**

SB 1100 also requires an interim reconciliation of the SNCP for each demonstration year. Each DPH's FY 2005-06 interim SNCP payments will be reconciled to its filed Medi-Cal 2552-96 cost report for the fiscal year ending June 30, 2006. The interim reconciliation process and payments for Demonstration Year 1 will occur in June 2007 and may result in an overpayment or underpayment to a DPH, which will be handled as follows:

- For DPHs that have been determined to be overpaid, the Department will recoup any overpayments.
- For DPHs that have been determined to be underpaid, the Department will make a payment equal to the difference between the Safety Net Care Pool (SNCP) payments that the DPHs have received and the SNCP payments estimated in the interim reconciliation process.

The interim reconciliation process for Demonstration Years 2-5 will occur each year in April following the close of the fiscal year. It is expected that any distributions to those DPHs who were underpaid will be made in the same fiscal year as the overpayments are recouped.

HOSP FINANCING - PRIVATE DSH REPLACEMENT

REGULAR POLICY CHANGE NUMBER:	76
IMPLEMENTATION DATE:	7/2005
ANALYST:	Karen Fairgrieves
FISCAL REFERENCE NUMBER:	1071

	FY 2006-07	FY 2007-08
FULL YEAR COST - TOTAL FUNDS	$558,114,000	$477,742,000
- STATE FUNDS	$279,057,000	$238,871,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$558,114,000	$477,742,000
STATE FUNDS	$279,057,000	$238,871,000
FEDERAL FUNDS	$279,057,000	$238,871,000

DESCRIPTION

Effective July 1, 2005, based on SB 1100, private hospitals receive Medi-Cal DSH replacement payment adjustments. These payment adjustments along with the $160.00 of the annual DSH allotment satisfy the State's payment obligations under the Federal DSH statute. The federal share of the DSH replacement payments is regular Title XIX funding and will not be claimed from the federal DSH allotment. The non-federal share of these payments is State General Fund. It is assumed that the DSH replacement payments will be made as follows on a cash basis:

FY 2006-07	**TF**	**GF**	**FFP**
2005-06	$ 120,184,000	$ 60,092,000	$ 60,092,000
2006-07	$ 437,930,000	$ 218,965,000	$ 218,965,000
	$ 558,114,000	**$ 279,057,000**	**$ 279,057,000**
FY 2007-08			
2006-07	$ 39,812,000	$ 19,906,000	$ 19,906,000
2007-08	$ 437,930,000	$ 218,965,000	$ 218,965,000
	$ 477,742,000	**$ 238,871,000**	**$ 238,871,000**

HOSP FINANCING - PRIVATE HOSPITAL SUPP PMT

REGULAR POLICY CHANGE NUMBER: 77
IMPLEMENTATION DATE: 7/2005
ANALYST: Karen Fairgrieves
FISCAL REFERENCE NUMBER: 1085

	FY 2006-07	FY 2007-08
FULL YEAR COST - TOTAL FUNDS	$358,014,000	$292,936,000
- STATE FUNDS	$179,007,000	$146,468,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$358,014,000	$292,936,000
STATE FUNDS	$179,007,000	$146,468,000
FEDERAL FUNDS	$179,007,000	$146,468,000

DESCRIPTION

Effective July 1, 2005, based on the requirements of SB 1100, supplemental reimbursement will be available to private hospitals. Private hospitals will receive payments from the Private Hospital Supplemental Fund (Item 4260-601-3097) using General Fund, intergovernmental transfers (IGTs), and interest accrued in the Private Hospital Supplemental Fund as the non-federal share of costs. Interest accrued in a fiscal year is assumed to be paid in the subsequent fiscal year. This funding along with the federal reimbursement, will replace the amount of funding the private hospitals previously received under the Emergency Services and Supplemental Payments Program (SB 1255, Voluntary Governmental Transfers), the Graduate Medical Education Program (GME), and the Small and Rural Hospital Supplemental Payment Program (Fund 688).

SB 1100 (Chapter 560, Statutes of 2005) requires the transfer of $118,400,000 annually from the General Fund (Item 4260-101-0001) to the Private Hospital Supplemental Fund to be used for the non-federal share of the supplemental payments. Part of the distribution of the Private Hospital Supplemental Fund will be based on the requirements specified in SB 1100, while the remainder will be subject to negotiations with the California Medical Assistance Commission.

Assumptions:

1. The State Funds (SF) item includes the annual General Fund appropriation, unspent funds from prior year, interest that has been accrued/estimated, and IGTs.
2. Beginning with FY 2006-07, and each year thereafter, the full annual allocation will be distributed in the same fiscal year.
3. IGTs will total $30,000,000 in FY 2006-07 and will generate $30,000,000 in FFP. In FY 2007-08, IGTs will total $27,000,000 and will generate $27,000,000 in FFP.

HOSP FINANCING - PRIVATE HOSPITAL SUPP PMT

REGULAR POLICY CHANGE NUMBER: 77

FY 2005-06	TF	SF	FFP
Appropriation (from GF)	$236,800,000	$118,400,000	$118,400,000
IGT	$45,618,500	$22,809,250	$22,809,250
Total	$282,418,500	$141,209,250	$141,209,250
Cash Expenditures in FY 2005-06	$223,340,500	$111,670,250	$111,670,250
FY 2005-06 Ending Balance	$59,078,000	$29,539,000	$29,539,000

FY 2006-07	TF	SF	FFP
FY 2005-06 Ending Balance	$59,078,000	$29,539,000	$29,539,000
Appropriation (from GF)	$236,800,000	$118,400,000	$118,400,000
FY 2005-06 interest	$2,136,000	$1,068,000	$1,068,000
IGT	$60,000,000	$30,000,000	$30,000,000
Total	$358,014,000	$179,007,000	$179,007,000
Est. Cash Expenditures in FY 2006-07	**$358,014,000**	**$179,007,000**	**$179,007,000**
FY 2006-07 Ending Balance	$0	$0	$0

FY 2007-08	TF	SF	FFP
Appropriation (from GF)	$236,800,000	$118,400,000	$118,400,000
Est. FY 2006-07 interest	$2,136,000	$1,068,000	$1,068,000
IGT	$54,000,000	$27,000,000	$27,000,000
Total	$292,936,000	$146,468,000	$146,468,000
Est. Cash Expenditures in FY 2007-08	**$292,936,000**	**$146,468,000**	**$146,468,000**
FY 2007-08 Ending Balance	$0	$0	$0

HOSP FINANCING-DPH PHYSICIAN & NON-PHYSICIAN COSTS

REGULAR POLICY CHANGE NUMBER: 78
IMPLEMENTATION DATE: 7/2007
ANALYST: Karen Fairgrieves
FISCAL REFERENCE NUMBER: 1078

	FY 2006-07	FY 2007-08
FULL YEAR COST - TOTAL FUNDS	$0	$154,860,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$154,860,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$154,860,000

DESCRIPTION

Effective July 1, 2005, based on SPA 05-023, reimbursement based on certified public expenditures will be available to designated public hospitals for their costs incurred for physician and non-physician practitioner professional services. The reimbursement will be available only for costs associated with health care services rendered to Medi-Cal beneficiaries who are patients of the hospital or its affiliated hospital and non-hospital settings. Reimbursements are for costs that are in excess of the payments received for services from any Medi-Cal source of reimbursement.

Assumptions:

1. Based on data provided by the California Association of Public Hospitals and Health Systems, the estimated payments for physician/non-physician costs in excess of any Medi-Cal payment are $50,000,000 for FY 2005-06.

2. Costs will increase at the rate identified in the Consumer Price Index (CPI) - All Urban Consumers for hospitals and related services (as reported in July of each year.)

3. The annual CPI for 2006 was 6.4%.

4. The annual CPIs for 2007 and 2008 are estimated at 5.93% each, (based on the CPI-U average for 2004 – 2006.)

5. Once payment systems are fully in place, eleven months of costs will be reimbursed in the same fiscal year incurred; one month of costs will be reimbursed in the following fiscal year. Reimbursement for DY 2005-06 and DY 2006-07 are expected to be fully paid in FY 2007-08.

HOSP FINANCING-DPH PHYSICIAN & NON-PHYSICIAN COSTS

REGULAR POLICY CHANGE NUMBER: 78

FY 2007-08			Estimated Annualized Expenditures	Months Pd in Fiscal Year	Estimated FY Expenditures
FY 2005-06			$ 50,000,000	12	$ 50,000,000
FY 2006-07	$50,000,000	106.40%	$ 53,200,000	12	$ 53,200,000
FY 2007-08	$53,200,000	105.93%	$ 56,356,533	11	$ 51,660,000
					$154,860,000

HOSP FINANCING - CCS AND GHPP

REGULAR POLICY CHANGE NUMBER: 79
IMPLEMENTATION DATE: 9/2005
ANALYST: Karen Fairgrieves
FISCAL REFERENCE NUMBER: 1108

	FY 2006-07	FY 2007-08
FULL YEAR COST - TOTAL FUNDS	$70,455,000	$26,000,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$70,455,000	$26,000,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$70,455,000	$26,000,000

DESCRIPTION

Effective September 1, 2005, based on the Special Terms and Conditions of the Medi-Cal Hospital/Uninsured Care Demonstration (MH/UCD), the Department may claim federal reimbursement for the California Children Services (CCS) Program and Genetically Handicapped Persons Program (GHPP) from the Safety Net Care Pool funding established by the MH/UCD. The CCS program provides diagnostic and treatment services, medical case management, and physical and occupational therapy health care services to children under 21 years of age with CCS-eligible conditions in families unable to afford catastrophic health care costs. The GHPP program provides comprehensive health care coverage for persons over 21 with specified genetic diseases including: cystic fibrosis; hemophilia; sickle cell disease and thalassemia; and chronic degenerative neurological diseases, including phenylketonuria.

This policy change reflects the 50 percent federal reimbursement received by the Department for a portion of the CCS and GHPP program claims based on the certification of public expenditures. Total eligible expenditures have been reduced by 17.79 percent to adjust for services provided to undocumented aliens. The FFP received for CCS and GHPP will be deposited in the Health Care Support Fund, Item 4260-601-7503. These funds are transferred to the Family Health Estimate, which is budgeted in Item 4260-111-0001. The General Fund savings created will be used to support safety net hospitals under the MH/UCD. The General Fund needed to support the safety net hospitals is currently less than the potential maximum of 50% of the expenditures for the four state-funded programs. CCS and GHPP are budgeted at their full federal reimbursement limit for FY 2006-07 and at the estimated support needed for the safety net hospitals for FY 2007-08.

	FY 2006-07 FFP	FY 2007-08 FFP
CCS	$53,170,000	$18,000,000
GHPP	$17,285,000	$8,000,000
Total	**$70,455,000**	**$26,000,000**

HOSP FINANCING - DISTRESSED HOSPITAL FUND

REGULAR POLICY CHANGE NUMBER:	80
IMPLEMENTATION DATE:	7/2006
ANALYST:	Karen Fairgrieves
FISCAL REFERENCE NUMBER:	1070

	FY 2006-07	FY 2007-08
FULL YEAR COST - TOTAL FUNDS	$58,450,000	$29,656,000
- STATE FUNDS	$29,225,000	$14,828,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$58,450,000	$29,656,000
STATE FUNDS	$29,225,000	$14,828,000
FEDERAL FUNDS	$29,225,000	$14,828,000

DESCRIPTION

Effective July 1, 2005, based on SB 1100, the Distressed Hospital Fund, Item 4260-601-8033, was established for hospitals that participate in the Selective Provider Contracting Program. SB 1100 requires the transfer of 20 percent of the July 2005 balance of the “Prior supplemental funds” (PSFs) to the Distressed Hospital Fund in each year for five years. PSFs are defined in SB 1100 as the following:

- Emergency Services and Supplemental Payments (ESSP) Fund, Item 4260-601-6093, (SB 1255, Voluntary Governmental Transfer);
- Medi-Cal Medical Education Supplemental Payment Fund, Item 4260-601-0550;
- Large Teaching Emphasis Hospital and Children’s Hospital Medi-Cal Medical Education Supplemental Payment Fund, Item 4260-601-0549;
- Small and Rural Hospital Supplemental Payment Fund, Item 4260-601-0688.

This funding, along with accrued interest in these funds, federal matching funds, and accrued interest in the Distressed Hospital Fund will be distributed through negotiations between the hospitals and the California Medical Assistance Commission (CMAC). Accrued interest is available for distribution in the fiscal year after it is earned.

Contract hospitals that meet the following requirements, as determined by CMAC, are eligible for distressed funds:

1. The hospital serves a substantial volume of Medi-Cal patients.

2. The hospital is a critical component of the Medi-Cal program's health care delivery system.

3. The hospital is facing a significant financial hardship.

It is assumed Distressed Hospital payments will be made on a cash basis as follows:

HOSP FINANCING – DISTRESSED HOSPITAL FUND

REGULAR POLICY CHANGE NUMBER: 80

FY 2006-07	**TF**	**SF**	**FFP**
FY 2005-06 Ending Balance	$27,200,000	$13,600,000	$13,600,000
FY 2005-06 Interest earned in Distressed Fund	$306,000	$153,000	$153,000
FY 2006-07 Transfer from Prior Supplemental Funds	$27,282,000	$13,641,000	$13,641,000
FY 2005-06 Interest earned in Prior Supplemental Funds	$3,662,000	$1,831,000	$1,831,000
FY 2006-07 Distressed Funds	$31,250,000	$15,625,000	$15,625,000
Distressed Funds Available	$58,450,000	$29,225,000	$29,225,000
Estimated Cash Expenditures	**$58,450,000**	**$29,225,000**	**$29,225,000**
FY 2006-07 Ending Balance	$0	$0	$0
FY 2007-08			
FY 2006-07 Ending Balance	$0	$0	$0
FY 2007-08 Transfer from Prior Supplemental Funds	$27,282,000	$13,641,000	$13,641,000
FY 2006-07 Est. Interest earned in Prior Supplemental Funds	$2,068,000	$1,034,000	$1,034,000
FY 2006-07 Est. Interest earned in Distressed Fund	$306,000	$153,000	$153,000
FY 2007-08 Distressed Funds	$29,656,000	$14,828,000	$14,828,000
Distressed Funds Available	$29,656,000	$14,828,000	$14,828,000
Estimated Cash Expenditures	**$29,656,000**	**$14,828,000**	**$14,828,000**
FY 2007-08 Ending Balance	$0	$0	$0

HOSP FINANCING - DPH INTERIM RATE GROWTH

REGULAR POLICY CHANGE NUMBER:	81
IMPLEMENTATION DATE:	7/2007
ANALYST:	Karen Fairgrieves
FISCAL REFERENCE NUMBER:	1162

	FY 2006-07	FY 2007-08
FULL YEAR COST - TOTAL FUNDS	$0	$27,181,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$27,181,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$27,181,000

DESCRIPTION

Effective July 1, 2005, based on SPA 05-021, Designated Public Hospitals (DPHs) receive interim per diem rates based on estimated costs using the hospitals' Medi-Cal costs trended forward. The DPHs' interim rate receives a growth percent increase to reflect an increase in hospital's costs. This growth increase is expected to be different from the former CMAC negotiated rate trend for some DPHs and requires an adjustment to the Medi-Cal Estimate base. The interim per diem rate consists of 100% federal funding.

Assumptions:

1. The DPHs received a 5.2% increase in their interim per diem rates for dates of service on or after July 1, 2006. This increase is 100% in the Medi-Cal base trends.
2. The DPHs will receive a 5.2% increase in their interim per diem rates for dates of service on or after July 1, 2007.
3. The FY 2007-08 annualized estimated expenditures included in the base trends are $792,647,000.
4. An additional annualized cost of $27,181,000 in excess of costs included in the base trends is estimated to occur in FY 2007-08.

HOSP FINANCING - NDPH SUPPLEMENTAL PMT

REGULAR POLICY CHANGE NUMBER:	82
IMPLEMENTATION DATE:	7/2005
ANALYST:	Karen Fairgrieves
FISCAL REFERENCE NUMBER:	1076

	FY 2006-07	FY 2007-08
FULL YEAR COST - TOTAL FUNDS	$3,898,000	$3,998,000
- STATE FUNDS	$1,949,000	$1,999,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$3,898,000	$3,998,000
STATE FUNDS	$1,949,000	$1,999,000
FEDERAL FUNDS	$1,949,000	$1,999,000

DESCRIPTION

Effective July 1, 2005, based on the requirements of SB 1100, supplemental reimbursement will be available to Nondesignated Public Hospitals (NDPHs). NDPHs will receive payments from the NDPH Supplemental Fund using State General Fund and interest accrued in the NDPH Supplemental Fund as the non-federal share of costs. It is assumed that interest accrued in a fiscal year will be paid in the subsequent fiscal year. This funding along with the federal reimbursement will replace the amount of funding the NDPHs previously received under the Emergency Services and Supplemental Payments Program (SB 1255, Voluntary Governmental Transfers).

Assumptions:

1. The State Funds (SF) item includes the annual General Fund appropriation, any unspent appropriations from prior years, interest that has been accrued/estimated, and IGTs.
2. SB 1100 (Chapter 560, Statutes of 2005) requires that $1,900,000 annually be transferred from the General Fund (Item 4260-101-0001) to the NDPH Supplemental Fund (Item 4260-601-3096) to be used for the non-federal share of payments.
3. Distribution of the NDPH Supplemental Fund will be determined through negotiations with the California Medical Assistance Commission.

HOSP FINANCING - NDPH SUPPLEMENTAL PMT

REGULAR POLICY CHANGE NUMBER: 82

FY 2005-06	**TF**	**SF**	**FFP**
Appropriation (from GF)	$3,800,000	$1,900,000	$1,900,000
Cash Expenditures in FY 2005-06	$3,700,000	$1,850,000	$1,850,000
FY 2005-06 Ending Balance	$100,000	$50,000	$50,000
FY 2006-07			
FY 2005-06 Ending Balance	$100,000	$50,000	$50,000
Appropriation (from GF)	$3,800,000	$1,900,000	$1,900,000
FY 2005-06 Interest Earned	$98,000	$49,000	$49,000
Total	$3,998,000	$1,999,000	$1,999,000
Est. Cash Expenditures in FY 2006-07	**$3,898,000**	**$1,949,000**	**$1,949,000**
FY 2006-07 Ending Balance	$100,000	$50,000	$50,000
FY 2007-08			
FY 2006-07 Ending Balance	$100,000	$50,000	$50,000
Appropriation (from GF)	$3,800,000	$1,900,000	$1,900,000
FY 2006-07 Interest Earned	$98,000	$49,000	$49,000
Total	$3,998,000	$1,999,000	$1,999,000
Est. Cash Expenditures in FY 2007-08	**$3,998,000**	**$1,999,000**	**$1,999,000**
FY 2007-08 Ending Balance	$0	$0	$0

HOSP FINANCING - HEALTH CARE COVERAGE

REGULAR POLICY CHANGE NUMBER: 83
IMPLEMENTATION DATE: 9/2007
ANALYST: Karen Fairgrieves
FISCAL REFERENCE NUMBER: 1154

	FY 2006-07	FY 2007-08
FULL YEAR COST - TOTAL FUNDS	$0	$150,000,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$150,000,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$150,000,000

DESCRIPTION

Under the MH/UCD, $180 million in federal funds is available annually to expand health care coverage to eligible low-income, uninsured persons for FY 2007-08 through FY 2009-10. SB 1448 (Chapter 76, Statutes of 2006) provides the statutory framework for the Health Care Coverage Initiative and directs the Department to issue a Request for Applications (RFA) to enable a county; a city and county; a consortium of more than one county; or a health authority to apply for an allocation of this federal funding.

Certified public expenditures (CPEs) submitted to the Department must reflect total fund expenditures for health care services provided. The Department will then submit the claim for FFP that will be reimbursed to the certifying entity. No GF will be expended for this program. Funding will be provided through the Health Care Support Fund, Item 4260-601-7503.

Enrollment will begin on September 1, 2007. The Department expects to distribute $150 million of the $180 million allocation for 2007-08 during FY 2007-08. The remaining $30 million for the 2007-08 allocation is expected to be distributed in FY 2008-09. The funding allocations have been awarded as follows:

HOSP FINANCING - HEALTH CARE COVERAGE

REGULAR POLICY CHANGE NUMBER: 83

County/Agency		Annual Allocations
Alameda County Health Care Services Agency	$	8,204,250
Contra Costa County/Contra Costa Health Services	$	15,250,000
County of Orange	$	16,871,578
County of San Diego, Health and Human Services Agency	$	13,040,000
Kern Medical Center	$	10,000,000
Los Angeles County Department of Health Services	$	54,000,000
San Francisco City and County	$	24,370,000
San Mateo Medical Center	$	7,564,172
Santa Clara Valley Health and Hospital System	$	20,700,000
Ventura County Health Care Agency	$	10,000,000
Total	$	180,000,000

HOSP FINANCING - DPH INTERIM RECONCILIATION

REGULAR POLICY CHANGE NUMBER:	84
IMPLEMENTATION DATE:	6/2007
ANALYST:	Karen Fairgrieves
FISCAL REFERENCE NUMBER:	1152

	FY 2006-07	FY 2007-08
FULL YEAR COST - TOTAL FUNDS	$40,565,000	$40,565,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$40,565,000	$40,565,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$40,565,000	$40,565,000

DESCRIPTION

Effective for dates of service on or after July 1, 2005, based on the Funding and Reimbursement Protocol in the Special Terms and Conditions of the Medi-Cal Hospital/Uninsured Care Demonstration (MH/UCD), each designated public hospital's (DPH) FY 2005-06 interim per diem rate, comprised of 100 percent federal funds, for inpatient hospital costs for Medi-Cal beneficiaries will be reconciled to its filed Medi-Cal 2552-96 cost report for the fiscal year ending June 30, 2006. Costs resulting from the Interim Reconciliation will be funded with federal funds, based on the hospitals' CPE.

This reconciliation process will occur in April each year and may result in an overpayment or underpayment to a DPH and will be handled as follows:

- For DPHs that have been determined to be overpaid, the Department will recoup any overpayments.
- For DPHs that have been determined to be underpaid, the Department will make a payment equal to the difference between the two rates multiplied by the number of qualified Medi-Cal days.

Final payment reconciliation will be completed when the Department has audited the hospitals' cost reports, which is expected to occur two years after the fiscal year end.

Assumptions:

1. DPHs' total interim rate payments (excluding administrative days) for dates of service for FY 2005-06 are estimated to be $758,235,000 FFP, based on payment data through January 2007.

2. DPHs' total inpatient 2005-06 cost for Medi-Cal beneficiaries from the filed Medi-Cal 2552-96 cost report is estimated to be $1,597,600,000 TF.

3. DPHs' interim reconciliation will be the difference between 50% of the filed Medi-Cal 2552-96 cost report and their interim rate payments.

4. The interim reconciliation for FY 2005-06 will be completed and paid in June 2007. The interim reconciliation for FY 2006-07 will be completed in April of FY 2007-08 and paid by June 2008.

HOSP FINANCING - DPH INTERIM RECONCILIATION

REGULAR POLICY CHANGE NUMBER: 84

5. The interim reconciliation for FY 2006-07 (completed in FY 2007-08) is estimated to cost the same as the prior year.

FY 2006-07

Est. Reported Cost for FY 2005-06:	$1,597,600,000	x 50% =	$798,800,000	
Est. Interim Rate Payments for FY 2005-06:			$758,235,000	
Est. Interim Reconciliation for FY 2005-06:			**$ 40,565,000**	FF

FY 2007-08

Est. Interim Reconciliation for FY 2006-07:			**$ 40,565,000**	FF

HOSP FINANCING - STABILIZATION FUNDING

REGULAR POLICY CHANGE NUMBER:	85
IMPLEMENTATION DATE:	7/2006
ANALYST:	Karen Fairgrieves
FISCAL REFERENCE NUMBER:	1153

	FY 2006-07	FY 2007-08
FULL YEAR COST - TOTAL FUNDS	$0	$56,300,000
- STATE FUNDS	$0	$28,150,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$56,300,000
STATE FUNDS	$0	$28,150,000
FEDERAL FUNDS	$0	$28,150,000

DESCRIPTION

Effective for dates of service on or after July 1, 2005, a portion of the total stabilization funding, comprised of FFP and GF as specified in W&I Code section 14166.20, will be distributed as follows:

- Non-designated public hospitals (NDPHs) will receive an amount equal to the difference between the 0.64 percent of the total stabilization funding and the aggregate payment increase in a fiscal year, compared with their aggregate baseline.
- Private hospitals will receive an amount equal to the difference between the total growth, including any rate and volume increase, and the sum of $42.5 million and their share of the 40/60 split, based on the formulas specified in W&I Code 14166.20.
- Distressed hospitals will receive total funds equal to the lesser of $23.5 million or 10 percent of the total stabilization funding.

Stabilization funding to NDPHs, private hospitals, and distressed hospitals is compromised of GF made available from the federalizing of four state-only programs, any additional GF needed, and 50% FFP. Stabilization funding is additional payments made to NDPHs, private hospitals, and distressed hospitals who have uncompensated Medi-Cal costs and whose Medi-Cal reimbursements have met their SB 1100 baseline payments.

Assumptions:

1. Stabilization funding is calculated after the interim reconciliation of the DPH interim payments is completed. The Department estimates $32,800,000 TF in stabilization funding will be needed for FY 2005-06. Due to the postponement of the interim reconciliation, from April 2007 to June 2007, the FY 2005-06 stabilization payments will be paid in FY 2007-08.

2. Stabilization funding for FY 2006-07 is expected to be paid in FY 2007-08 and is estimated to be $23,500,000 TF.

HOSP FINANCING - STABILIZATION FUNDING

REGULAR POLICY CHANGE NUMBER: 85

FY 2007-08	**TF**	**GF**
FY 2005-06 Stabilization Payments	$ 32,800,000	$ 16,400,000
FY 2006-07 Stabilization Payments	$ 23,500,000	$ 11,750,000
Total	**$ 56,300,000**	**$ 28,150,000**

HOSP FINANCING - BCCTP

REGULAR POLICY CHANGE NUMBER:	86
IMPLEMENTATION DATE:	9/2005
ANALYST:	Karen Fairgrieves
FISCAL REFERENCE NUMBER:	1084

	FY 2006-07	FY 2007-08
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	-$291,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	-$291,000	$0
FEDERAL FUNDS	$291,000	$0

DESCRIPTION

The Budget Act of 2001 (Chapter 106, Statutes of 2001) authorized the Breast and Cervical Cancer Treatment Program (BCCTP) effective January 1, 2002, for women under 200% of the FPL.

A State-Only program covers women aged 65 or older, women with inadequate health coverage, undocumented women, and males for cancer treatment only. The coverage term is 18 months for breast cancer and 2 years for cervical cancer. Beneficiaries are screened through Centers for Disease Control (CDC) and Family PACT providers.

Effective September 1, 2005, based on the Special Terms and Conditions of the Medi-Cal Hospital Uninsured Care Demonstration (MH/UCD) waiver, the Department may claim federal reimbursement for State-Only BCCTP costs from the Safety Net Care Pool (SNCP) funding established in the MH/UCD. Funding is claimed for services provided to undocumented aliens under aid code 0U.

This policy change reflects the adjustment for the federal reimbursement received by the Department for a portion of the State-Only BCCTP costs, based on the certification of public expenditures. The General Fund savings created from the federalization of the State-Only BCCTP, and three other state-funded programs, will be used to support safety net hospitals under the MH/UCD. The General Fund needed to support the safety net hospitals is currently less than the potential maximum of 50% of the expenditures for the four state-funded programs. To maximize the usage of the MH/UCD federal funding, the Department will only claim the amount of federal funds needed to support the safety net hospitals. It is estimated that no SNCP funding for BCCTP will be needed in FY 2007-08.

The FFP is budgeted in the Health Care Support Fund Item 4260-601-7503.

	FFP
FY 2006-07	**$291,000**

BASE ADJUSTMENT - DPH INTERIM RATE

REGULAR POLICY CHANGE NUMBER:	87
IMPLEMENTATION DATE:	7/2005
ANALYST:	Karen Fairgrieves
FISCAL REFERENCE NUMBER:	1161

	FY 2006-07	FY 2007-08
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	-$389,978,500	-$364,500,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	-$389,978,500	-$364,500,000
FEDERAL FUNDS	$389,978,500	$364,500,000

DESCRIPTION

Effective July 1, 2005, based on SPA 05-021, Designated Public Hospitals (DPHs) no longer received CMAC negotiated per diem rates for inpatient hospital costs for services rendered to Medi-Cal beneficiaries on and after July 1, 2005. DPHs receive an interim per diem rate based on estimated costs using the hospitals' Medi-Cal cost trended forward. These interim payments are 100% federal funds matching the hospitals' certified public expenditures (CPEs), resulting in 50% FFP and 50% CPE.

The previous CMAC negotiated per diem rates were paid with 50% FFP and 50% GF. The interim rate change is 100% in the Medi-Cal Estimate base total dollar trend. Typically, the items in the Medi-Cal Estimate base trend are paid with 50% FFP and 50% GF. Since the DPH interim rate is paid with 100% FFP, an adjustment to shift from 50% GF to 100% FFP is currently done quarterly.

Assumptions:

1. The annualized FFP expenditures are estimated to be $792,647,000 in FY 2006-07. The GF adjustment for June 2007 will occur in FY 2007-08.

2. The total growth represented in the base trends for DPHs in FY 2007-08 is estimated to be 11.52% from FY 2006-07. The GF adjustment for April – June 2008 will occur in FY 2008-09.

3. The total growth includes the growth for total days and the growth in rates.

4. An adjustment of $53,364,000 for payments in FY 2005-06 was made in November 2006.

BASE ADJUSTMENT - DPH INTERIM RATE

REGULAR POLICY CHANGE NUMBER: 87

FY 2006-07:	Expenditures	GF to FF Shift
FY 2006-07 Est. Per Diem Expenditures	$ 792,647,000	$ 396,323,500
June 2007 Adjustment	$ (66,054,000)	$ (33,027,000)
FY 2005-06 Expenditures adjusted in FY 2006-07	$ 53,364,000	$ 26,682,000
FY 2006-07 Est. Total Adjustment	**$ 779,957,000**	**$ 389,978,500**
FY 2007-08:		
FY 2006-07 Est. Per Diem Expenditures	$ 792,647,000	$ 396,323,500
FY 2007-08 Growth	11.52%	11.52%
FY 2007-08 Est. Per Diem Expenditures	$ 883,928,000	$ 441,964,000
April – June 2008 Adjustment	$(220,982,000)	$(110,491,000)
June 2007 Adjustment	$ 66,054,000	$ 33,027,000
FY 2007-08 Est. Total Adjustment	**$ 729,000,000**	**$ 364,500,000**

HOSP FINANCING - MIA LTC

REGULAR POLICY CHANGE NUMBER:	88
IMPLEMENTATION DATE:	9/2005
ANALYST:	Karen Fairgrieves
FISCAL REFERENCE NUMBER:	1079

	FY 2006-07	FY 2007-08
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	-$7,328,000	-$10,570,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	-$7,328,000	-$10,570,000
FEDERAL FUNDS	$7,328,000	$10,570,000

DESCRIPTION

Effective September 1, 2005, based on the Special Terms and Conditions of the Medi-Cal Hospital/Uninsured Care Demonstration (MH/UCD), the Department may claim federal reimbursement for the Medically Indigent Adult Long-Term Care (MIA LTC) program from the Safety Net Care Pool (SNCP) funding established by the MH/UCD. The MIA LTC program is a State-Only funded program that covers persons ages 21 to 65 who do not have linkage to another program and who are citizens or legal residents and are residing in a Nursing Facility Level A or B.

This policy change reflects the adjustment for the federal reimbursement received by the Department for a portion of the MIA LTC program claims based on the certification of public expenditures. The General Fund savings created will be used to support safety net hospitals under the MH/UCD. The General Fund needed to support the safety net hospitals is currently less than the potential maximum of 50% of the expenditures for the four state-funded programs. To maximize the usage of the MH/UCD federal funding, the Department will only claim the amount of federal funds needed to support the safety net hospitals.

The FFP is budgeted in the Health Care Support Fund Item 4260-601-7503.

	FFP
FY 2006-07	**$ 7,328,000**
FY 2007-08	**$10,570,000**

HOSP FINANCING - DPH RATE RECONCILIATION

REGULAR POLICY CHANGE NUMBER: 89
IMPLEMENTATION DATE: 7/2007
ANALYST: Karen Fairgrieves
FISCAL REFERENCE NUMBER: 1113

	FY 2006-07	FY 2007-08
FULL YEAR COST - TOTAL FUNDS	$0	-$30,528,000
- STATE FUNDS	$0	-$30,528,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	-$30,528,000
STATE FUNDS	$0	-$30,528,000
FEDERAL FUNDS	$0	$0

DESCRIPTION

Effective July 1, 2005, based on the Medi-Cal Hospital/Uncompensated Care Demonstration (MH/UCD), Designated Public Hospitals (DPHs) no longer receive negotiated per diem rates for inpatient hospital costs for services rendered to Medi-Cal beneficiaries on or after July 1, 2005. DPHs instead receive interim per diem rates based on certified public expenditures for providing inpatient hospital care to Medi-Cal beneficiaries. Interim payments will be 100% FFP.

The Department continued to pay the DPHs the negotiated per diem rates until May 21, 2006. The negotiated per diem rates consisted of 50 percent GF and 50 percent FFP and were paid until the Department implemented interim per diem rates based on DPHs' certified public expenditures. All DPH claims paid at the negotiated per diem rates for services between July 1, 2005 and May 21, 2006 were reprocessed with the new interim per diem rates in June 2006.

Those hospitals whose new interim per diem rate was higher than the negotiated per diem rate were paid the additional FFP owed and the Department reimbursed the GF with FFP.

Those hospitals whose new interim per diem rate was lower than the negotiated per diem rate were overpaid. The Department claimed the correct FFP based on the new interim per diem rate and reimbursed the GF.

Assumptions:

1. The remaining GF repayment owed by DPHs whose new interim per diem rate was lower than the previously negotiated per diem rate will be offset from the future payments for physician and non-physician professional services when the State Plan Amendment (SPA) is approved in FY 2006-07.
2. This repayment is expected to occur by August 2007.
3. The Department will be reimbursed $30,528,000 GF from this offset.

CAPITAL PROJECT DEBT REIMBURSEMENT

REGULAR POLICY CHANGE NUMBER:	90
IMPLEMENTATION DATE:	7/1991
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	82

	FY 2006-07	FY 2007-08
FULL YEAR COST - TOTAL FUNDS	$139,535,000	$104,156,000
- STATE FUNDS	$69,767,500	$52,078,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$139,535,000	$104,156,000
STATE FUNDS	$69,767,500	$52,078,000
FEDERAL FUNDS	$69,767,500	$52,078,000

DESCRIPTION

SB 1732 (Chapter 1635, Statutes of 1988), and SB 2665 (Chapter 1310, Statutes of 1990) authorize Medi-Cal reimbursement of revenue and general obligation bond debt for principal and interest costs incurred in the construction, renovation and replacement of qualifying hospital facilities, i.e., disproportionate share contract hospitals.

Estimates include any FMAP changes. These funds are budgeted in Items 4260-102-0001 and 4260-102-0890.

	Total Funds	GF	FFP
FY 2006-07	**$139,535,000**	**$69,767,500**	**$69,767,500**
FY 2007-08	**$104,156,000**	**$52,078,000**	**$52,078,000**

HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENT

REGULAR POLICY CHANGE NUMBER: 91
IMPLEMENTATION DATE: 4/2004
ANALYST: Robert Ducay
FISCAL REFERENCE NUMBER: 78

	FY 2006-07	FY 2007-08
FULL YEAR COST - TOTAL FUNDS	$120,000,000	$125,000,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$120,000,000	$125,000,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$120,000,000	$125,000,000

DESCRIPTION

AB 915 (Chapter 747, Statutes of 2002) created a supplemental reimbursement program for publicly owned or operated hospital outpatient departments. Hospitals will now receive outpatient supplemental payments based on certified public expenditures for providing outpatient hospital care to Medi-Cal beneficiaries. The supplemental amount, when combined with the amount received from all other sources of Medi-Cal Fee for Service reimbursement, cannot exceed 100% of the costs of providing services to Medi-Cal beneficiaries by the participating facilities. The non-federal match used to draw down FFP is paid exclusively with funds from the participating facilities.

Payments of $120 million FFP will be made in June 2007 for services provided in FY 2005-06; payments of $125 million are expected to be made in June 2008 for services provided in FY 2006-07.

Projected costs are as follows:

	FY 2006-07	**FY 2007-08**
FY 2005-06 FFP payment	$120,000,000	
FY 2006-07 FFP payment		$125,000,000
Total	**$120,000,000**	**$125,000,000**

IGT FOR NON-SB 1100 HOSPITALS

REGULAR POLICY CHANGE NUMBER: 92
IMPLEMENTATION DATE: 7/2006
ANALYST: Karen Fairgrieves
FISCAL REFERENCE NUMBER: 1158

	FY 2006-07	FY 2007-08
FULL YEAR COST - TOTAL FUNDS	$100,000,000	$100,000,000
- STATE FUNDS	$50,000,000	$50,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$100,000,000	$100,000,000
STATE FUNDS	$50,000,000	$50,000,000
FEDERAL FUNDS	$50,000,000	$50,000,000

DESCRIPTION

W & I Code, Section 14164, provides general authority for the Department to accept IGTs from any governmental entity in the state in support of the Medi-Cal program. Non-SB 1100 hospitals are expected to request that the Department accept an IGT for federal matching and return the IGT transfer funds and federal match funds to the non-SB 1100 hospital. This policy change provides authority to accept the IGTs and match them with federal funds.

The Department has entered into an Interagency Agreement (IA) with Contra Costa County. Contra Costa County will transfer $10 million in an IGT to the Department to be matched with federal funds and distributed to Doctors Medical Center San Pablo/Pinole.

	IGT	FFP	Total
FY 2006-07	$ 50,000,000	$ 50,000,000	**$100,000,000**
FY 2007-08	$ 50,000,000	$ 50,000,000	**$100,000,000**

FFP FOR LOCAL TRAUMA CENTERS

REGULAR POLICY CHANGE NUMBER: 93
IMPLEMENTATION DATE: 2/2006
ANALYST: Robert Ducay
FISCAL REFERENCE NUMBER: 104

	FY 2006-07	FY 2007-08
FULL YEAR COST - TOTAL FUNDS	$65,000,000	$44,000,000
- STATE FUNDS	$32,500,000	$22,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$65,000,000	$44,000,000
STATE FUNDS	$32,500,000	$22,000,000
FEDERAL FUNDS	$32,500,000	$22,000,000

DESCRIPTION

In the Budget Act of 2003 and the 2003 Health Care Trailer Bill (AB 1762), the Legislature authorized Los Angeles and Alameda Counties to transfer funds to the Medi-Cal program to be matched with Title XIX federal funds. The State Plan Amendment was approved March 31, 2005. Under the authority of Sections 14164 and 14087.3 of the Welfare and Institutions Code, the Department will use the funds to offset costs of care at local trauma care centers throughout the counties. Payments for Alameda County began in February 2006 and were retroactive to July 1, 2003. Payments for Los Angeles County began in April 2006 and were retroactive to July 1, 2003. Retroactive payments of $23,000,000 for FY 2005-06 will be paid in FY 2006-07.

The non-federal match is paid by Los Angeles and Alameda Counties through the Special Deposit Fund 4260-601-0942142.

FY 2006-07	**Fund 4260-601-0942142**	**FFP**	**Total**
FY 2005-06 Retro	$11,500,000	$11,500,000	$23,000,000
FY 2006-07	$21,000,000	$21,000,000	$42,000,000
Total	**$32,500,000**	**$32,500,000**	**$65,000,000**

FY 2007-08	**Fund 4260-601-0942142**	**FFP**	**Total**
FY 2007-08	**$22,000,000**	**$22,000,000**	**$44,000,000**

CERTIFICATION PAYMENTS FOR DP-NFS

REGULAR POLICY CHANGE NUMBER:	94
IMPLEMENTATION DATE:	6/2002
ANALYST:	Robert Ducay
FISCAL REFERENCE NUMBER:	86

	FY 2006-07	FY 2007-08
FULL YEAR COST - TOTAL FUNDS	$50,000,000	$50,000,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$50,000,000	$50,000,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$50,000,000	$50,000,000

DESCRIPTION

The Budget Act of 2001, authorized payment of federal financial participation (FFP) based on Certified Public Expenditures (CPE) to Nursing Facilities (NF) that are Distinct Parts (DP) of acute care hospitals. The acute care hospital must be owned and operated by a public entity, such as a city, county, or health care district. This program is designed to allow DP-NFs to claim federal financial participation on the difference between their projected costs and the amount Medi-Cal currently pays under the existing program.

Payments are not made through the fiscal intermediary; consequently, they are not reflected in the Medi-Cal base trend data and must be budgeted in this policy change. Expenditures projected for FY 2006-07 and FY 2007-08 are $50,000,000 FFP in each fiscal year.

	FY 2006-07	**FY 2007-08**
FFP based on CPEs	**$50,000,000**	**$50,000,000**

DSH OUTPATIENT PAYMENT METHOD CHANGE

REGULAR POLICY CHANGE NUMBER:	95
IMPLEMENTATION DATE:	1/2005
ANALYST:	Robert Ducay
FISCAL REFERENCE NUMBER:	1038

	FY 2006-07	FY 2007-08
FULL YEAR COST - TOTAL FUNDS	$10,000,000	$10,000,000
- STATE FUNDS	$5,000,000	$5,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$10,000,000	$10,000,000
STATE FUNDS	$5,000,000	$5,000,000
FEDERAL FUNDS	$5,000,000	$5,000,000

DESCRIPTION

This policy change reflects the change in payment methodology for the Outpatient Disproportionate Share Hospital (DSH) program. Outpatient DSH has a total cap of $10,000,000 when combined with federal matching funds.

Prior to January 1, 2005, the Department paid each hospital by authorizing the Fiscal Intermediary to increase each hospital's claims by a percentage factor using the methodology specified in statute. In order to provide a more efficient way to reimburse hospitals, effective January 1, 2005 eligible providers are reimbursed on a quarterly basis through a payment action notice (PAN). The payment represents one quarter of the total annual amount due to each eligible hospital. Due to the payment being made at the end of a quarter, the last quarter of each fiscal year will be paid the following fiscal year.

Assumption:

1. For FY 2006-07, FY 2007-08, and annually, assume a total of $10,000,000 will be paid through PANs.

	FY 2006-07	**FY 2007-08**
Annual Payment	**$10,000,000**	**$10,000,000**

SRH OUTPATIENT PAYMENT METHOD CHANGE

REGULAR POLICY CHANGE NUMBER:	96
IMPLEMENTATION DATE:	1/2005
ANALYST:	Robert Ducay
FISCAL REFERENCE NUMBER:	1039

	FY 2006-07	FY 2007-08
FULL YEAR COST - TOTAL FUNDS	$8,000,000	$8,000,000
- STATE FUNDS	$4,000,000	$4,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$8,000,000	$8,000,000
STATE FUNDS	$4,000,000	$4,000,000
FEDERAL FUNDS	$4,000,000	$4,000,000

DESCRIPTION

This policy change reflects the change in payment methodology for the Outpatient Small and Rural Hospital (SRH) program. Outpatient SRH has a total cap of $8,000,000 when combined with federal matching funds.

Prior to January 1, 2005, the Department paid each hospital by authorizing the Fiscal Intermediary to increase each hospital's claims by a percentage factor using the methodology specified in statute. In order to provide a more efficient way to reimburse hospitals, effective January 1, 2005 eligible providers are reimbursed on a quarterly basis through a payment action notice (PAN). The payment represents one quarter of the total annual amount due to each eligible hospital. Due to the payment being made at the end of a quarter, the last quarter of each fiscal year will be paid the following fiscal year.

Assumption:

1. For FY 2006-07, FY 2007-08, and annually, assume a total of $8,000,000 will be paid through PANs.

	FY 2006-07	**FY 2007-08**
Annual Payment	**$8,000,000**	**$8,000,000**

DSH PAYMENTS

REGULAR POLICY CHANGE NUMBER:	97
IMPLEMENTATION DATE:	7/1992
ANALYST:	Karen Fairgrieves
FISCAL REFERENCE NUMBER:	73

	FY 2006-07	FY 2007-08
FULL YEAR COST - TOTAL FUNDS	$2,209,000	$0
- STATE FUNDS	$1,104,500	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$2,209,000	$0
STATE FUNDS	$1,104,500	$0
FEDERAL FUNDS	$1,104,500	$0

DESCRIPTION

SB 855 (Chapter 279/91) and SB 146 (Chapter 1046/91) established the Medi-Cal Inpatient Payment Adjustment (MIPA) Fund (Item 4260-606-0834). Public (transferor) entities make intergovernmental transfers (IGTs) to the MIPA Fund. Funds are allocated from the MIPA Fund to Disproportionate Share Hospitals (DSH) by the Department and matched by federal funds.

California's annual DSH federal allotment is $1,032,580,000.

Assumptions:

1. Effective July 1, 2005, based on the Special Terms and Conditions of the Medi-Cal Hospital/Uninsured Demonstration (MH/UCD) Project, the federal DSH allotments are only available for uncompensated Medi-Cal and uninsured costs incurred by designated and non-designated public hospitals. See the Hospital Financing DSH Payments policy change for DSH payments under the MH/UCD.
2. This policy change reflects remaining $2,209,000 from DSH Year 2005 that will be paid in FY 2006-07.

DSH YR	SFY	Qtr	Total
FFY 2005	2006-07	4	**$2,209,000**

FREESTANDING CLINICS & VETERANS' HOMES SUPPL.

REGULAR POLICY CHANGE NUMBER:	98
IMPLEMENTATION DATE:	7/2007
ANALYST:	Robert Ducay
FISCAL REFERENCE NUMBER:	1140

	FY 2006-07	FY 2007-08
FULL YEAR COST - TOTAL FUNDS	$0	$65,000,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$65,000,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$65,000,000

DESCRIPTION

AB 959 (Chapter 162, Statutes of 2006) adds freestanding, non-hospital based clinics and state veterans homes to the current Medi-Cal supplemental payment program. Under this program, freestanding, non-hospital based clinics that are enrolled as Medi-Cal providers and are owned or operated by the State, city, county, city and county, the University of California, or health care district would be eligible to receive supplemental payments. The supplemental payment, when combined with the amount received from all other sources of reimbursement, cannot exceed 100% of the costs of providing services to Medi-Cal beneficiaries incurred by the participating facilities. The non-federal match to draw down FFP is paid from the public funds of the participating facilities and does not involve State General Funds for non-state facilities. Supplemental payments to freestanding, non-hospital based clinics are expected to total $60,000,000 annually.

State veterans homes that are enrolled as Medi-Cal providers and are operated by the State are also eligible to receive supplemental payments. Eligible state veterans homes may claim FFP on the difference between their projected costs and the amount Medi-Cal currently pays under the existing program. The non-federal match to draw down FFP will be paid from the public funds of the eligible state veterans homes. These payments are expected to total $5,000,000 annually.

Supplemental payments to state veterans homes will be effective retroactively beginning the rate year starting August 1, 2006, pending the approval of a State Plan Amendment. Supplemental payments to freestanding, non-hospital based clinics will be effective retroactively beginning July 1, 2006, pending an approved State Plan Amendment. Both freestanding, non-hospital based clinics and state veterans homes will be paid on an annual basis. Since facilities must submit cost reports and the Department must certify expenditures before FFP can be granted, supplemental payments for services provided during a fiscal year will not be issued until the following fiscal year. Supplemental payments for both state veterans homes and freestanding, non-hospital based clinics are expected to begin in FY 2007-08.

FREESTANDING CLINICS & VETERANS' HOMES SUPPL.

REGULAR POLICY CHANGE NUMBER: 98

	FY 2007-08
Freestanding Outpatient Clinics	$60,000,000
State Veterans' Homes	$5,000,000
Total FFP	**$65,000,000**

HEALTHY FAMILIES - CDMH

REGULAR POLICY CHANGE NUMBER:	110
IMPLEMENTATION DATE:	7/1998
ANALYST:	Betty Lai
FISCAL REFERENCE NUMBER:	89

	FY 2006-07	FY 2007-08
FULL YEAR COST - TOTAL FUNDS	$40,394,000	$24,002,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$40,394,000	$24,002,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$40,394,000	$24,002,000

DESCRIPTION

This policy change reflects the FFP portion only for the program cost of providing additional services to severely emotionally disturbed children who have exhausted Healthy Families mental health benefits. This estimate was provided by the California Department of Mental Health (CDMH). As of FY 2006-07, CDHS no longer budgets the GF for CDMH Medi-Cal Services. The GF is included in the CDMH budget.

CASH BASIS

	CDHS FFP	County Match	IA #
FY 2006-07	**$40,394,000**	$22,257,000	02-25271
FY 2007-08	**$24,002,000**	$13,228,000	02-25271

FMAP changes are reflected in this policy change.
*Funding is through Item 4260-113-0890 (Title XXI).

NURSE-TO-PATIENT RATIOS FOR HOSPITALS

REGULAR POLICY CHANGE NUMBER: 111
IMPLEMENTATION DATE: 7/2006
ANALYST: Betty Lai
FISCAL REFERENCE NUMBER: 101

	FY 2006-07	FY 2007-08
FULL YEAR COST - TOTAL FUNDS	$14,682,000	$18,105,000
- STATE FUNDS	$7,341,000	$9,052,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$14,682,000	$18,105,000
STATE FUNDS	$7,341,000	$9,052,500
FEDERAL FUNDS	$7,341,000	$9,052,500

DESCRIPTION

AB 394 (Chapter 945, Statutes of 1999) required the Department to adopt regulations that establish minimum, specific licensed nurse-to-patient ratios by nurse classification and hospital unit for general acute care and psychiatric hospitals. The regulations specify the number of patients that may be assigned per licensed nurse in the following hospital units: critical care, burn, labor and delivery, postanesthesia, emergency, surgery, pediatric, step-down/intermediate care, specialty care, telemetry, general medical care, subacute care, and transitional inpatient care.

Assumptions:

1. The initial regulations became effective January 1, 2004.

2. On January 1, 2005, the nurse-to-patient ratio for medical, surgical, and combined medical-surgical units, and mixed units further changed from 1:6 to 1:5.

3. Non-contract hospital costs for the nurse-staffing ratio changes are paid during the cost settlement process, approximately two years after implementation. This policy change includes:

   *The 2004-05 costs for nurse staffing ratio increases implemented in January 2004 and January 2005, which are expected to be paid in 2006-07.

   *The 2005-06 costs which are expected to be paid in 2007-08.

4. Contract hospital costs are part of California Medical Assistance Commission negotiations. There are no separate negotiations for specific items such as the change in nurse staffing ratio; therefore, no increase in costs for contract hospitals is assumed.

5. Managed care costs have been incorporated into the managed care rates and are budgeted in the managed care policy changes.

MINOR CONSENT SETTLEMENT

REGULAR POLICY CHANGE NUMBER:	114
IMPLEMENTATION DATE:	7/2003
ANALYST:	Stella Bertrand
FISCAL REFERENCE NUMBER:	103

	FY 2006-07	FY 2007-08
FULL YEAR COST - TOTAL FUNDS	$9,467,000	$9,098,000
- STATE FUNDS	$9,467,000	$9,098,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$9,467,000	$9,098,000
STATE FUNDS	$9,467,000	$9,098,000
FEDERAL FUNDS	$0	$0

DESCRIPTION

On June 17, 2002, the Department, Los Angeles County, and the U.S. Department of Justice executed a settlement agreement concerning an audit by the federal Office of the Inspector General relating to the incorrect claiming of FFP for services (especially mental health services) provided to minor consent eligibles from 1993 to 1999. The terms of the settlement include payment of $73.5 million plus interest, of which Los Angeles County paid $6.8 million. The balance of $66,500,000 plus interest will be withheld from California's Medicaid payments over ten years, with the first "adjustment" made on July 1, 2003.

	FY 2006-07	FY 2007-08
Total General Fund Cost	**$9,467,000**	**$9,098,000**

TWO-PLAN MODEL NOTICES OF DISPUTE

REGULAR POLICY CHANGE NUMBER:	118
IMPLEMENTATION DATE:	7/1998
ANALYST:	Stella Bertrand
FISCAL REFERENCE NUMBER:	95

	FY 2006-07	FY 2007-08
FULL YEAR COST - TOTAL FUNDS	$1,000,000	$1,000,000
- STATE FUNDS	$1,000,000	$1,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,000,000	$1,000,000
STATE FUNDS	$1,000,000	$1,000,000
FEDERAL FUNDS	$0	$0

DESCRIPTION

This policy change includes funds for settlement agreements for disputes between the Department and the Two-Plan managed care models.

ESTATE RECOVERY REGULATIONS

REGULAR POLICY CHANGE NUMBER: 120
IMPLEMENTATION DATE: 5/2006
ANALYST: Betty Lai
FISCAL REFERENCE NUMBER: 1043

	FY 2006-07	FY 2007-08
FULL YEAR COST - TOTAL FUNDS	$2,173,000	$2,173,000
- STATE FUNDS	$1,086,500	$1,086,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	65.60 %	41.10 %
APPLIED TO BASE		
TOTAL FUNDS	$747,500	$1,279,900
STATE FUNDS	$373,760	$639,950
FEDERAL FUNDS	$373,760	$639,950

DESCRIPTION

Regulation package R-32-00: Estate Recovery Regulations effective May 2006, is based on the recent settlement agreement in the case of *California Advocates for Nursing Home Reform et al. v. Diana M. Bontá et al*. that requires the Department to make specific amendments to Medi-Cal estate recovery regulations in three different phases. These amendments make a number of clarifying changes to the estate recovery regulations that have a potential fiscal impact and are as follows:

1. Revision of the definition of an estate to include retirement accounts and life insurance policies that revert to the estate. Indeterminate insignificant savings since few accounts/policies revert to the estate.

2. Exclusion of personal care services in the list of services for which recoveries can be made from the estate. No impact as recoveries are not currently collected for personal care services.

3. Addition to regulations that the Department may collect from estates for the cost of institutional care provided to persons under 55. This change is expected to result in indeterminate minor savings, as it is difficult to track care given to persons under age 55 long enough for collection.

4. Addition of an exemption from estate recovery for undue hardship when the person seeking the waiver from recovery provided care to the decedent for two or more years while living in the home with the decedent and that care delayed the decedent's admission to a medical or long-term care institution.

The Department began processing R-32 exemption requests in March 2007.

ESTATE RECOVERY REGULATIONS

REGULAR POLICY CHANGE NUMBER: 120

Assumptions:

A. The Department currently receives 36 hardship waiver requests per month regarding estate recovery claims.

B. Approximately 30% of recent hardship waiver requests have been related to R-32.

C. Approximately 11 requests per month will meet the requirements for an exemption.

D. Based on FY 2005-06, the average estate recovery collection is $16,464.

FY 2006-07 and ongoing: 11 X 12 X $16,464 = **$2,173,000** lost collections

FFP REPAYMENT-SPECIALTY MENTAL HEALTH

REGULAR POLICY CHANGE NUMBER:	121
IMPLEMENTATION DATE:	5/2005
ANALYST:	Betty Lai
FISCAL REFERENCE NUMBER:	1051

	FY 2006-07	FY 2007-08
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$1,900,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$1,900,000	$0
FEDERAL FUNDS	-$1,900,000	$0

DESCRIPTION

The Department has agreed to repay CMS for an overpayment within the Specialty Mental Health Services Waiver administered by CDMH through an Interagency Agreement with CDHS. In its oversight role, CDMH identified overpayments to Tri-Cities, a subcontractor of the Los Angeles County Mental Health Plan, of approximately $6.3 million in FFP for Fiscal Years 1996-97, 1998-99, 2001-02, 2002-03, and 2003-04.

On February 13, 2004, Tri-Cities, a Joint Powers Authority composed of the cities of Claremont, La Verne, and Pomona, filed Chapter 9 bankruptcy. As part of the bankruptcy proceedings, Tri-Cities identified the total overpayment amount as $9.1 million in FFP. However, the audits are now complete and the total overpayment amount has been determined to be $8.2 million. CDHS repaid $6.3 million to CMS in FY 2004-05. The remainder due to CMS is $1.9 million, which is expected to be paid in FY 2006-07.

CIGARETTE AND TOBACCO SURTAX FUNDS

REGULAR POLICY CHANGE NUMBER:	122
IMPLEMENTATION DATE:	1/2006
ANALYST:	Robert Ducay
FISCAL REFERENCE NUMBER:	1087

	FY 2006-07	FY 2007-08
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$0

DESCRIPTION

Cigarette and Tobacco Products Surtax (CTPS/Proposition 99) funds have been allocated to aid in the funding of the *Orthopaedic Hospital* settlement for FY 2006-07 and FY 2007-08. The *Orthopaedic Hospital* settlement increased hospital outpatient rates by a total of 43.44% between 2001 and 2004.

FY 2006-07

Hospital Services Account	4260-101-0232	$18,000,000
Unallocated Acount	4260-101-0236	$18,784,000
Total		**$36,784,000**

FY 2007-08

Hospital Services Account	4260-101-0232	$18,000,000
Unallocated Acount	4260-101-0236	$18,784,000
Total		**$36,784,000**

This funding is identified in the management summary funding pages.

INDIAN HEALTH SERVICES

REGULAR POLICY CHANGE NUMBER:	124
IMPLEMENTATION DATE:	4/1998
ANALYST:	Betty Lai
FISCAL REFERENCE NUMBER:	111

	FY 2006-07	FY 2007-08
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	-$7,700,000	-$6,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	-$7,700,000	-$6,000,000
FEDERAL FUNDS	$7,700,000	$6,000,000

DESCRIPTION

CMS will provide 100% federal funds for services provided by Indian health clinics to Native Americans eligible for Medi-Cal. This policy change reflects the additional federal financial participation for those identifiable services entitled to full federal funding.

Assumptions:

1. Currently, there are 47 Indian health clinics participating.
2. Due to a change in methodology in identifying Native Americans who are eligible for Medi-Cal, the Department will be claiming an additional $1,700,000 in retroactive claims in FY 2006-07 for January 2005 to June 2006.
3. Based on actual federal funds claimed for 39 Indian health clinics in FY 2005-06, the Department has projected the following:

	FY 2006-07	**FY 2007-08**
FFP	$6,000,000	$6,000,000
Retroactive adjustments	$1,700,000	$0
Total	**$7,700,000**	**$6,000,000**

ANTI-FRAUD EXPANSION FOR FY 2004-05

REGULAR POLICY CHANGE NUMBER:	125
IMPLEMENTATION DATE:	7/2004
ANALYST:	Robert Ducay
FISCAL REFERENCE NUMBER:	205

	FY 2006-07	FY 2007-08
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	100.00 %	100.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$0

DESCRIPTION

Based on additional staffing provided in the FY 2000-01 and FY 2003-04 Budgets, the Department expanded its anti-fraud activities. The annualized savings shown below are the estimated savings based on sanctions that the Department's Audits and Investigations Division (A&I) completed in FY 2004-05.

The savings takes shifts in beneficiary costs into account by using the "findings to paid claims ratio" from anti-fraud audits as reported by A&I. This ratio demonstrates the amount of legitimate claims vs. fraudulent/erroneous claims and was applied to Denied Reenrollments, Deactivations, Withholds, and Temporary Suspensions. Audits for Recoveries (AFR) were added to the anti-fraud savings calculations. The Department is determining additional methods to allow for a more precise savings calculation.

Also included in the savings were sixteen Deactivations which were issued in FY 2003-04, but were not processed until FY 2004-05. These too received the adjustment for shifted beneficiary costs.

These savings have been fully incorporated into the base estimate. The purpose of this policy change is to provide information on actual savings based on actions taken against providers in FY 2004-05. This information is used in estimating savings for anti-fraud expansion activities in FY 2006-07 and FY 2007-08.

ANTI-FRAUD EXPANSION FOR FY 2004-05

REGULAR POLICY CHANGE NUMBER: 125

Activity	Number of Actions	Savings Per Action	Savings Annualized
Denied Reenrollments	184	$47,817	$8,798,000
Withholds and Temporary Suspensions	284	$41,015	$11,648,000
AFR Residual	85	$143,835	$12,226,000
Deactivations	252	$53,303	$13,432,000
Special Claims Review and Provider Prior Authorization	437	$121,412	$53,057,000
Provider Feedback Letters	1,735	$8,433	$14,631,000
Beneficiary Confirmation Letters	2,934	$5,784	$16,971,000
Procedure Code Limits	23	$18,250	$420,000
Trust Accounts			$1,969,000
Sanction Total			$133,152,000
Past Deactivations	16	$1,220,313	$19,525,000
Total Savings			$152,677,000

NON-INSTITUTIONAL PROVIDER OVERPAYMENTS

REGULAR POLICY CHANGE NUMBER: 126
IMPLEMENTATION DATE: 10/2006
ANALYST: Betty Lai
FISCAL REFERENCE NUMBER: 1103

	FY 2006-07	FY 2007-08
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$128,000,000	$48,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$128,000,000	$48,000,000
FEDERAL FUNDS	-$128,000,000	-$48,000,000

DESCRIPTION

CDHS conducted internal audits that identified FFP that was being incorrectly reported for non-institutional provider overpayments. In order to correct the reporting, changes in the Department's COBRA system were implemented in April 2006, and data sampling was conducted through June 2006 to test the accuracy of these system changes. The repayment of FFP for overpayments identified after July 1, 2006 began in FY 2006-07. The Department expects to pay back the 50% share of the newly identified non-institutional provider overpayment cases, which is anticipated to be approximately $12 million per quarter. On a cash basis, the Department will pay back three quarters of FFP in FY 2006-07, which is $36 million, and $48 million annually thereafter.

The repayment of $92 million FFP owed for overpayments identified prior to July 1, 2006 will be made in FY 2006-07. These are debts that are less that two years old, liened debts, debts that are under appeal, and debts that have repayment agreements that exceed two years.

If any of these debts are subsequently discovered to be uncollectible, the Department will initiate the necessary documentation to obtain reimbursement from CMS.

STATE-ONLY IMD ANCILLARY SERVICES

REGULAR POLICY CHANGE NUMBER: 127
IMPLEMENTATION DATE: 7/1999
ANALYST: Betty Lai
FISCAL REFERENCE NUMBER: 35

	FY 2006-07	FY 2007-08
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$36,000,000	$12,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$36,000,000	$12,000,000
FEDERAL FUNDS	-$36,000,000	-$12,000,000

DESCRIPTION

This policy change includes funds to repay improperly claimed FFP for ancillary services for Medi-Cal beneficiaries residing in institutions for mental diseases (IMDs). Ancillary services provided to Medi-Cal beneficiaries who are ages 22 through 64 residing in IMDs are not eligible for FFP. Ancillary services (e.g. physician services, pharmacy, laboratory services, etc.) for beneficiaries residing in IMDs became totally state funded as of July 1, 1999. Because separate aid codes or other identifiers are not available to indicate a Medi-Cal beneficary is residing in an IMD, repayment of the FFP is calculated retrospectively based on information on impacted beneficiaries provided by the California Department of Mental Health.

This policy change reflects FMAP changes.

Services Rec'd	FY 2006-07 Repayment	FY 2007-08 Repayment
10/01/03-09/30/04	$12,000,000	$0
10/01/04-09/30/05	$12,000,000	$0
10/01/05-09/30/06	$12,000,000	$0
10/01/06-09/30/07	$0	$12,000,000
Total	**$36,000,000**	**$12,000,000**

ANTI-FRAUD EXPANSION FOR FY 2007-08

REGULAR POLICY CHANGE NUMBER:	128
IMPLEMENTATION DATE:	7/2007
ANALYST:	Robert Ducay
FISCAL REFERENCE NUMBER:	1144

	FY 2006-07	FY 2007-08
FULL YEAR COST - TOTAL FUNDS	$0	-$49,684,000
- STATE FUNDS	$0	-$24,842,000
PAYMENT LAG	1.0000	0.8550
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	-$42,479,800
STATE FUNDS	$0	-$21,239,910
FEDERAL FUNDS	$0	-$21,239,910

DESCRIPTION

Based on additional staffing provided in the FY 2000-01 and FY 2003-04 Budgets, the Department expanded its anti-fraud activities. Actual activities that the Department's Audits and Investigations Division (A&I) has indicated it will begin in FY 2007-08 are multiplied by the actual average savings in provider payments per reported action from FY 2004-05.

The estimated savings takes shifts in beneficiary costs into account by using the "findings to paid claims ratio" from anti-fraud audits as reported by A&I. This ratio demonstrates the amount of legitimate claims vs. fraudulent/erroneous claims and was applied to Denied Reenrollments, Deactivations, Withholds, and Temporary Suspensions. Audits for Recoveries (AFR) were added to the anti-fraud savings calculations. The Department is determining additional methods to allow for a more precise savings calculation.

Self-audits and compliance audits are newly implemented anti-fraud measures. Self audits are conducted by the provider at the request of the Department to identify improper billings resulting in overpayments of certain procedures. Compliance audits are a review by the Department of provider accounts, records, and activities to ensure adequacy of controls and test for policy and procedure compliance. Currently, no savings can be estimated for these activities due to lack of historical data. Savings from these actions will be calculated in the future once more data is collected.

A&I is also scheduled to complete a series of Lab Reviews and Beneficiary Care Management sanctions. They also plan to issue Provider Feedback Letters and Beneficiary Confirmation Letters. Currently, no savings can be estimated for these projects because the variability in savings amounts for the FY 2004-05 actual data is so great that predicting true savings becomes difficult.

Annualized Savings for FY 2007-08 anti-fraud activities will be realized beginning in FY 2008-09.

ANTI-FRAUD EXPANSION FOR FY 2007-08

REGULAR POLICY CHANGE NUMBER: 128

(Dollars in Thousands) Activity	Estimated Number of Actions	SAVINGS FY 2007-08	Annualized
Denied Reenrollments	60	$1,554	$2,869
Withholds and Temporary Suspensions	200	$4,443	$8,203
Special Claims Review and Provider Prior Authorization	350	$22,094	$40,788
AFR Residual	100	$7,791	$14,384
Procedure Code Limits	120	$1,186	$2,190
Deactivations	400	$11,549	$21,321
Trust Accounts		$1,067	$1,969
Savings Total		**$49,684**	$91,724

MEDICAL SUPPORT ENHANCEMENTS

REGULAR POLICY CHANGE NUMBER:	129
IMPLEMENTATION DATE:	7/2007
ANALYST:	Betty Lai
FISCAL REFERENCE NUMBER:	1065

	FY 2006-07	FY 2007-08
FULL YEAR COST - TOTAL FUNDS	$0	-$2,034,000
- STATE FUNDS	$0	-$1,017,000
PAYMENT LAG	1.0000	0.8550
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	-$1,739,100
STATE FUNDS	$0	-$869,540
FEDERAL FUNDS	$0	-$869,540

DESCRIPTION

The Budget Act of 2003 included savings for a Medical Support Enhancement program. This program is designed to extend the IV-D Children program statewide. The IV-D Children program requires, through court orders, absent parents who have private health insurance, or who can afford cost-effective, county-acquired insurance, to pay for the health insurance needs of their children. The enhancement to the California Child Support Automation System (CCSAS) will allow for the automation of processing other health care coverage (OHC) referrals.

Assumptions:

1. Automation will result in the determination of OHC immediately, rather than the one month delay for manual processing. Therefore, there will be one additional month of OHC per case.
2. 2,658 OHC referrals from counties are received each month.
3. 90% have OHC.
4. The average amount of OHC savings is $70.85 per beneficiary per month based on a comparison of calendar year 2004 costs for children with and without OHC.
5. The enhancement will be implemented in June 2007 and savings will begin in July 2007.

   2,658 x .9 x $70.85 = $169,487 monthly savings
   $169,487 x 12 = **$2,034,000 FY 2007-08 savings**

GLAXOSMITHKLINE SETTLEMENT

REGULAR POLICY CHANGE NUMBER: 130
IMPLEMENTATION DATE: 7/2006
ANALYST: Karen Fairgrieves
FISCAL REFERENCE NUMBER: 1136

	FY 2006-07	FY 2007-08
FULL YEAR COST - TOTAL FUNDS	-$1,246,000	$0
- STATE FUNDS	-$1,246,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	100.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$0

DESCRIPTION

In a settlement of a False Claims Act lawsuit, the drug manufacturer GlaxoSmithKline agreed to pay restitution to state Medicaid programs. The lawsuit was associated with drug pricing activities of the company for two injectable drugs. According to the settlement, California’s recovery is $2,492,178.58 (50%FFP/50% GF), of which $1,246,089.29 went to Medi-Cal as the state-only portion of the recovery. Payment was received in December 2006.

EDS COST CONTAINMENT PROJECTS

REGULAR POLICY CHANGE NUMBER:	131
IMPLEMENTATION DATE:	7/1993
ANALYST:	Robert Ducay
FISCAL REFERENCE NUMBER:	124

	FY 2006-07	FY 2007-08
FULL YEAR COST - TOTAL FUNDS	-$2,184,000	-$3,047,000
- STATE FUNDS	-$1,092,000	-$1,523,500
PAYMENT LAG	0.7876	0.9880
% REFLECTED IN BASE	68.54 %	44.95 %
APPLIED TO BASE		
TOTAL FUNDS	-$541,100	-$1,657,200
STATE FUNDS	-$270,570	-$828,620
FEDERAL FUNDS	-$270,580	-$828,620

DESCRIPTION

Electronic Data Systems (EDS) is implementing the following proposals to contain Medi-Cal costs, which are not yet fully reflected in the base estimate:

Project Number	Impl. Date	Title	FY 2006-07 Savings	FY 2007-08 Savings
03-11	1-Aug-06	POS for Psychology	$275,000	$300,000
01-16	1-Aug-06	Psych Services	$917,000	$1,000,000
06-04	5-Sep-06	Fetal Doppler Echocardiography	$201,000	$241,000
06-07	5-Sep-06	Obstetric Panel	$75,000	$90,000
06-10	1-Oct-06	OB vs Non-OB US Diagnosis Restriction	$440,000	$586,000
06-12	1-Mar-07	New vs. Established Physician Visit Audit	$276,000	$830,000
	TOTAL		**$2,184,000**	**$3,047,000**

NEW RECOVERY ACTIVITIES

REGULAR POLICY CHANGE NUMBER: 132
IMPLEMENTATION DATE: 8/2005
ANALYST: Betty Lai
FISCAL REFERENCE NUMBER: 1026

	FY 2006-07	FY 2007-08
FULL YEAR COST - TOTAL FUNDS	-$21,814,000	-$27,900,000
- STATE FUNDS	-$10,907,000	-$13,950,000
PAYMENT LAG	0.8934	1.0000
% REFLECTED IN BASE	74.43 %	57.34 %
APPLIED TO BASE		
TOTAL FUNDS	-$4,983,200	-$11,902,100
STATE FUNDS	-$2,491,620	-$5,951,070
FEDERAL FUNDS	-$2,491,620	-$5,951,070

DESCRIPTION

The Budget Act of 2005 increased the CDHS's Health Insurance and Recovery programs. Staffing augmentations in the Estate Recovery and Personal Injury (PI) Units are expected to increase collections. In addition, staffing augmentations for Health Insurance programs and contracting for other health coverage (OHC) identification will increase private health insurance billings and enrollment in the Health Insurance Premium Payment Program (HIPP). Savings are identified below, by the implementation date of each activity and the current year (CY), budget year (BY) and annual savings. Payment lag factors have been applied to the CY and BY savings estimates. (Percent in base calculations not reflected.)

Program	Imp. Date	FY 2006-07 Savings (Lagged)	FY 2007-08 Savings (Lagged)	Annual Savings
1. Recover PI Expenses of Managed Care Beneficiaries	03/06	$1,531,000	$1,900,000	$1,900,000
2. Enhance Estate Recover/ Pers. Injury Collections	12/08	$0	$0	$14,000,000
3b.OHC Augmentation/ Incr. Recoveries	03/06	$1,353,000	$1,680,000	$1,680,000
4. Private Health Insurance Billings (HIR) Group Rec.	12/05	$3,350,000	$3,600,000	$3,600,000
5a.OHC Identification/ Deflected Payments	04/06	$12,675,000	$20,000,000	$20,000,000
5b.OHC Identification/ Increase Recoveries	04/06	$580,000	$720,000	$720,000
Total		**$19,489,000**	**$27,900,000**	**$41,900,000**

The following programs are fully incorporated in the Medi-Cal base estimate:
3a. OHC Augmentation/Deflected Pmts
5c. Medicare Buy-In System

ANTI-FRAUD EXPANSION FOR FY 2006-07

REGULAR POLICY CHANGE NUMBER:	134
IMPLEMENTATION DATE:	7/2006
ANALYST:	Robert Ducay
FISCAL REFERENCE NUMBER:	1093

	FY 2006-07	FY 2007-08
FULL YEAR COST - TOTAL FUNDS	-$47,699,000	-$88,060,000
- STATE FUNDS	-$23,849,500	-$44,030,000
PAYMENT LAG	0.8550	1.0000
% REFLECTED IN BASE	54.80 %	25.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$18,433,800	-$66,045,000
STATE FUNDS	-$9,216,880	-$33,022,500
FEDERAL FUNDS	-$9,216,880	-$33,022,500

DESCRIPTION

Based on additional staffing provided in the FY 2000-01 and FY 2003-04 Budgets, the Department expanded its anti-fraud activities. Actual activities that the Department's Audits and Investigations Division (A&I) has indicated it will begin in FY 2006-07 are multiplied by the actual average savings in provider payments per reported action from FY 2004-05.

The estimated savings takes shifts in beneficiary costs into account by using the "findings to paid claims ratio" from anti-fraud audits as reported by A&I. This ratio demonstrates the amount of legitimate claims vs. fraudulent/erroneous claims and was applied to Denied Reenrollments, Deactivations, Withholds, and Temporary Suspensions. Audits for Recoveries (AFR) were added to the anti-fraud savings calculations. The Department is determining additional methods to allow for a more precise savings calculation.

Self-audits and compliance audits are newly implemented anti-fraud measures. Self audits are conducted by the provider at the request of the Department to identify improper billings resulting in overpayments of certain procedures. Compliance audits are a review by the Department of provider accounts, records, and activities to ensure adequacy of controls and test for policy and procedure compliance. Currently, no savings can be estimated for these activities due to lack of historical data. Savings from these actions will be calculated in the future once more data is collected.

A&I is also scheduled to complete a series of Lab Reviews and Beneficiary Care Management sanctions. They also plan to issue Provider Feedback Letters and Beneficiary Confirmation Letters. Currently, no savings can be estimated for these projects because the variability in savings amounts from the FY 2004-05 actual data was so great that predicting true savings becomes difficult.

A&I is conducting unannounced on-site visits to Adult Day Health Centers (ADHC). The ADHCs selected for the on-site visits are identified during the Medi-Cal Payment Error Study (MPES) or were referred by the California Department of Aging. Data will not be available until FY 2008-09 to determine this measure’s true impact.

ANTI-FRAUD EXPANSION FOR FY 2006-07

REGULAR POLICY CHANGE NUMBER: 134

Annualized Savings will be realized beginning in FY 2007-08.

(*Dollars in Thousands*) Activity	Estimated Number of Actions	SAVINGS FY 2006-07	SAVINGS Annualized
Denied Reenrollments	90	$2,331	$4,304
Withholds and Temporary Suspensions	150	$3,332	$6,152
Special Claims Review and Provider Prior Authorization	350	$22,094	$40,788
AFR Residual	75	$5,843	$10,788
Deactivations	400	$11,549	$21,321
Procedure Code Limits	150	$1,483	$2,738
Trust Accounts		$1,067	$1,969
Savings Total		**$47,699**	**$88,060**

RECLAMATION OF FFP PAID THROUGH COBRA

REGULAR POLICY CHANGE NUMBER:	136
IMPLEMENTATION DATE:	4/2007
ANALYST:	Betty Lai
FISCAL REFERENCE NUMBER:	1176

	FY 2006-07	FY 2007-08
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	-$20,870,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	-$20,870,000	$0
FEDERAL FUNDS	$20,870,000	$0

DESCRIPTION

The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 required that the federal government be reimbursed its share of all provider overpayments in the quarter in which the 60th day after discovery of an overpayment falls. After changes in the Department's COBRA System became operational in July 2006, the Department discovered that FFP had been incorrectly reported on (1) some monies that had been refunded to providers and (2) for certain provider overpayments associated with the County Medical Services Program (CMSP). FFP is not owed for debts resulting from audits of claims for other medical programs in which the federal government does not share the costs, such as CMSP, nor for amounts refunded to providers as a result of collections in excess of what they owe. In both instances, no FFP should have been reported. The Department will reclaim $20.87 million in incorrectly reported FFP in FY 2006-07. The claim covers the period of October 1, 1985 to October 31, 2006. CMS has been notified and procedural changes have been implemented to ensure accurate repayments.

DENTAL FI UNDERWRITING GAIN

REGULAR POLICY CHANGE NUMBER:	137
IMPLEMENTATION DATE:	11/2006
ANALYST:	Beverly Yokoi
FISCAL REFERENCE NUMBER:	1177

	FY 2006-07	FY 2007-08
FULL YEAR COST - TOTAL FUNDS	-$131,718,000	$0
- STATE FUNDS	-$63,537,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$131,718,000	$0
STATE FUNDS	-$63,537,000	$0
FEDERAL FUNDS	-$68,181,000	$0

DESCRIPTION

In November 2006, Delta Dental paid the Department $131,718,000 (TF) based on the results of a contractually required independent audit. Dental contract provisions require that Delta Dental obtain an annual independent audit to determine any underwriting gain or loss, and specify the gain or loss sharing ratios with the State. The underwriting gain or loss is based on a comparison of the total premiums paid by the Department and actual expenditures incurred by Delta Dental. The November 2006 payment by Delta Dental was for the period August 2003 through April 2005 and covered an extended audit period due to a nine-month extension of the multiyear contract.

	FY 2006-07
Total Funds	**-$131,718,000**
General Fund	**-$63,537,000**

ENHANCED RECOVERIES GENERATED BY DRA OF 2005

REGULAR POLICY CHANGE NUMBER:	138
IMPLEMENTATION DATE:	10/2007
ANALYST:	Betty Lai
FISCAL REFERENCE NUMBER:	1178

	FY 2006-07	FY 2007-08
FULL YEAR COST - TOTAL FUNDS	$0	-$1,500,000
- STATE FUNDS	$0	-$750,000
PAYMENT LAG	1.0000	0.8110
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	-$1,216,500
STATE FUNDS	$0	-$608,250
FEDERAL FUNDS	$0	-$608,250

DESCRIPTION

The DRA of 2005 clarified the definition of legally liable health insurers that are responsible for payment of health care items or services to include pharmacy benefit managers (PBMs). The Department has proposed trailer bill language that will avoid conflict with federal law and compel PBMs to comply with the Department's attempts to collect monies owed to the Medi-Cal program. The DRA revision and proposed trailer bill language are expected to result in increased recoveries, as PBMs will have a clearly defined legal obligation to reimburse Medi-Cal. Additional recoveries are expected to begin within three months after the State budget is passed. The Department estimates an additional $2,000,000 annually will be received as a result of this change.

Annual Savings $2,000,000
FY 2007-08 Savings $2,000,000 / 12 X 9 months = **$1,500,000**

MEDICAL SUPPLY REBATES

REGULAR POLICY CHANGE NUMBER:	139
IMPLEMENTATION DATE:	10/2006
ANALYST:	Karen Fairgrieves
FISCAL REFERENCE NUMBER:	1181

	FY 2006-07	FY 2007-08
FULL YEAR COST - TOTAL FUNDS	-$3,700,000	-$3,500,000
- STATE FUNDS	-$1,850,000	-$1,750,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$3,700,000	-$3,500,000
STATE FUNDS	-$1,850,000	-$1,750,000
FEDERAL FUNDS	-$1,850,000	-$1,750,000

DESCRIPTION

The Department is contracting for medical supply rebates, beginning with diabetic supply products. Due to modifications needed to the Rebate Accounting Information System (RAIS), manually created invoices are being sent to manufacturers. Manual invoicing of rebates started in December 2006 for the 4th quarter of 2004 through the 3rd quarter of 2006.

	Medical Supply Rebates	
Est. FY 2006-07	**$ 3,700,000**	Cash
Est. FY 2007-08	**$ 3,500,000**	Cash

DISPUTED DRUG REBATE RESOLUTIONS

REGULAR POLICY CHANGE NUMBER: 140
IMPLEMENTATION DATE: 7/2006
ANALYST: Karen Fairgrieves
FISCAL REFERENCE NUMBER: 1182

	FY 2006-07	FY 2007-08
FULL YEAR COST - TOTAL FUNDS	-$63,000,000	-$40,000,000
- STATE FUNDS	-$31,214,000	-$19,937,600
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$63,000,000	-$40,000,000
STATE FUNDS	-$31,214,000	-$19,937,600
FEDERAL FUNDS	-$31,786,000	-$20,062,400

DESCRIPTION

The Department collects drug rebates, as required by federal and state laws. Rebate invoices are sent quarterly to drug manufacturers and payment is due within 38 days from the invoice postmark date. Manufacturers may pay late, not pay, or pay a portion and formally dispute the remaining amount of rebates owed. Disputed rebates are defined as being 15 days past due. The Department works to resolve these disputes and to receive payment.

Monies from resolved disputed rebates from 1991 to the 2nd quarter of 2002 are considered Aged Drug Rebates and are budgeted separately in the Medi-Cal Estimate. Monies from the resolution of disputed rebates from the 3rd quarter of 2002 to the present are considered Disputed Drug Rebates and had previously been budgeted in the Federal Drug Rebates, State Supplemental Rebates, and FPACT Rebates policy changes.

The Department expects to collect $63 million in disputed drug rebates during FY 2006-07 and $40 million during FY 2007-08, assuming the current level of staffing is maintained.

	Federal & State Rebates	FPACT Rebates	**Total Rebates**
FY 2006-07	$61,000,000	$ 2,000,000	**$63,000,000**
FY 2007-08	$40,000,000		**$40,000,000**

HOME TOCOLYTIC THERAPY

REGULAR POLICY CHANGE NUMBER: 141
IMPLEMENTATION DATE: 7/2007
ANALYST: Julie Chan
FISCAL REFERENCE NUMBER: 1183

	FY 2006-07	FY 2007-08
FULL YEAR COST - TOTAL FUNDS	$0	$4,312,000
- STATE FUNDS	$0	$2,156,000
PAYMENT LAG	1.0000	0.6950
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$2,996,800
STATE FUNDS	$0	$1,498,420
FEDERAL FUNDS	$0	$1,498,420

DESCRIPTION

SB 1528 (Chapter 666, Statutes of 2006) required Medi-Cal to provide coverage of home infusion treatment with tocolytic agents for pregnant women to control preterm labor. While at home, pregnant women can have tocolytic agents administered via a subcutaneous pump. These women would be monitored by a home uterine activity monitor. Telephonic nursing and pharmacy support is available 24 hour a day. Home visits are also performed as needed. Services are expected to begin in July 2007.

SB 1528 also requires an evaluation of the effectiveness of infusion treatments with tocolytic agents by October 1, 2009. This statute sunsets on January 1, 2010. Services are expected to begin in July 2007.

Assumptions:

1. The cost for home tocolytic therapy for a pregnant Medi-Cal beneficiary is estimated to be $220 per day. The average treatment will last 8 weeks. $220 x 7 days = $1,540 per week. $1,540 x 8 week treatment = $12,320.

2. According to Matria, a company that provides this service, 350 pregnant Medi-Cal beneficiaries would utilize this therapy each year. 350 x $12,320 = $4,312,000 annual costs

3. The estimated cost of the assessment is $750,000. The assessment costs will begin in July 2008.

4. Based on the Medi-Cal Delivery Report for 2004, 73% of Medi-Cal births are paid for by FFS and 27% by managed care. Based on this ratio, the cost to managed care is $1,164,000 in FY 2007-08.

FY 2007-08	TF	GF	FF
FFS	$3,148,000	$1,574,000	$1,574,000
Managed Care	$1,164,000	$582,000	$582,000
Total	**$4,312,000**	**$2,156,000**	**$2,156,000**

DRA - MINOR CONSENT

REGULAR POLICY CHANGE NUMBER:	142
IMPLEMENTATION DATE:	7/2007
ANALYST:	Stella Bertrand
FISCAL REFERENCE NUMBER:	1184

	FY 2006-07	FY 2007-08
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$0	$20,043,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$0	$20,043,500
FEDERAL FUNDS	$0	-$20,043,500

DESCRIPTION

The All County Welfare Directors Letter to implement the Deficit Reduction Act of 2005 (DRA) exempts Minor Consent applicants and beneficiaries from presenting evidence of citizenship and identity. As a result, the Department will no longer claim FFP for the Minor Consent program for pregnant minors.

Assumptions:

1. Current costs for aid code 7N under the Minor Consent program (pregnant minors) are 50% GF and 50% FFP.

2. The costs will shift to 100% GF beginning July 1, 2007.

3. EDS expenditures for the 7N aid code were $40,086,594 for calendar year 2006.

4. It is estimated that the federal funds to GF shift will be as follows:

FY 2007-08	Current Funding	Revised Funding	Change
Total	$40,087,000	$40,087,000	$0
GF	$20,043,500	$40,087,000	$20,043,500
FFP	**$20,043,500**	$0	**-$20,043,500**

DENTAL RETROACTIVE RATE CHANGES

REGULAR POLICY CHANGE NUMBER:	143
IMPLEMENTATION DATE:	6/2006
ANALYST:	Beverly Yokoi
FISCAL REFERENCE NUMBER:	1185

	FY 2006-07	FY 2007-08
FULL YEAR COST - TOTAL FUNDS	-$44,005,000	-$603,000
- STATE FUNDS	-$22,002,500	-$301,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$44,005,000	-$603,000
STATE FUNDS	-$22,002,500	-$301,500
FEDERAL FUNDS	-$22,002,500	-$301,500

DESCRIPTION

Dental rates were reduced for the period August 2005 through July 2006 from $9.22 to $8.52 for regular eligibles, and from $51.24 to $34.99 for refugees. This policy change includes the retroactive adjustment for FY 2005-06 that will be implemented in May 2007 and the retroactive adjustment for FY 2006-07 that will be implemented in August 2007.

The adjustment for rates paid in FY 2006-07 for the rates effective August 2005 are shown in the Base Dental Service policy change.

FY 2006-07	**FY 2005-06 Rate**	**Rate Effective 8/2005**	**Change**	**FY 05-06 Monthly Eligibles**	**FY 2005-06 Retro Rate Savings Adjustment (11 months)**
Regular	$9.22	$8.52	($0.70)	5,671,315	($43,669,000)
Refugee	$51.24	$34.99	($16.25)	1,878	(336,000)
					($44,005,000)

FY 2007-08	**FY 2005-06 Rate**	**Rate Effective 8/2006**	**Change**	**FY 06-07 Monthly Eligibles**	**FY 2006-07 Retro Rate Savings Adjustment (11 months)**
Regular	$8.52	$8.51	($.01)	5,680,076	($625,000)
Refugee	$34.99	$35.92	$.93	2,167	+22,000
					($603,000)

CAPITATED RATE METHODOLOGY PROJECT RATE INCREASES

REGULAR POLICY CHANGE NUMBER:	145
IMPLEMENTATION DATE:	7/2007
ANALYST:	Shelley Stankeivicz
FISCAL REFERENCE NUMBER:	1187

	FY 2006-07	FY 2007-08
FULL YEAR COST - TOTAL FUNDS	$0	$214,285,000
- STATE FUNDS	$0	$107,142,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$214,285,000
STATE FUNDS	$0	$107,142,500
FEDERAL FUNDS	$0	$107,142,500

DESCRIPTION

The Department engaged Mercer Government Human Resources Consulting in May 2005 to review the Medi-Cal base data, and to recommend opportunities for improvement to the current capitation rate development process and reimbursement structure. Mercer has issued a report to the Department that recommends the Department adopt a plan-specific, experience-based rate methodology, in which capitation payments to contracted health plans are matched to their relative risk. Managed care rates will be adjusted to reflect the Mercer findings, effective with each plan's 2007-08 rate year.

	FY 2007-08	Annual Cost
County Organized Health Systems		
(Rate Year: July 1 – June 30)	$63,642,000	$63,642,000
Two Plan Model		
(Rate Year: October 1 – September 30)	$131,800,000	$175,733,000
Geographic Managed Care – Sacramento		
(Rate Year: January 1 – December 31)	$6,282,000	$12,564,000
Geographic Managed Care – San Diego		
(Rate Year: July 1 – June 30)	$12,561,000	$12,561,000
Total Capitated Rate Adjustment	**$214,285,000**	$264,500,000

SBRHA CARVE-OUT OF AIDS DRUGS

REGULAR POLICY CHANGE NUMBER:	147
IMPLEMENTATION DATE:	1/2007
ANALYST:	Shelley Stankeivicz
FISCAL REFERENCE NUMBER:	1189

	FY 2006-07	FY 2007-08
FULL YEAR COST - TOTAL FUNDS	-$17,000	$0
- STATE FUNDS	-$8,500	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$17,000	$0
STATE FUNDS	-$8,500	$0
FEDERAL FUNDS	-$8,500	$0

DESCRIPTION

The remaining drugs associated with the treatment of AIDS have been carved out for the Santa Barbara Regional Health Authority because they are no longer in the plan's contracted scope, effective January 1, 2007. The Department is adjusting rates accordingly and the cost for the drugs will be shifted to fee-for-service.

The AIDS drugs carved out of the Santa Barbara Regional Health Authority rates are (listed by generic name):

Stavudine, Lamivudine, Saqinavir Mesylate, Ritonavir, Indinavir sulfate, Nelfinavir Mesylate, Nevirapine, Dlavirding Mesylate, Zidovudine/Lamivudine, Saquinavir, Efavirenz, Abacavir Sulfate, Amprenavir, Lopinavir/Ritonavir, Abacavir/Zidovudine/Lamivudine, Tenofovir Disoproxil Fumarate, Enfuvirtide, Atazanavir Sulfate, Emricitabine, and Fosamprenavir Calcium.

Assumptions:

1. Based on the difference in the AIDS rate for Santa Barbara with the drugs in and the drugs out, and the number of persons receiving that rate, the annual cost of the drugs being carved out is estimated to be $310,000.

2. The FY 2006-07 FFS cost is expected to be:

   $310,000 x .5 = $155,000
   $155,000 x .8860 lag factor = $138,000

	FY 2006-07	**FY 2007-08**
Capitation Savings	-$155,000	-$310,000
FFS Costs	$138,000	$310,000
Net Savings	**-$17,000**	$0

MANAGED CARE ELIGIBILITY ADJUSTMENTS

REGULAR POLICY CHANGE NUMBER: 148
IMPLEMENTATION DATE: 10/2007
ANALYST: Shelley Stankeivicz
FISCAL REFERENCE NUMBER: 1150

	FY 2006-07	FY 2007-08
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$0	$823,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$0	$823,000
FEDERAL FUNDS	$0	-$823,000

DESCRIPTION

An audit by the Bureau of State Audits found that the Department made managed care capitation payments for deceased plan members. This occurred because the system in use at the time, upon notice of a beneficiary's death, would disenroll the deceased beneficiary prospectively and not retroactively. The Department has instituted a new process wherein deceased beneficiaries are removed from MEDS based on the date of their deaths and capitated payments to the plans are retroactively adjusted back to the date of death.

Repayment is due to CMS for the federal portion of the incorrect payments. Repayment of the federal share, $823,000, will be made in October 2007. The repayment of the federal portion is broken down by plan type as follows:

	Repayment	Eligibles
County Organized Health System	$460,000	9,199
Two-Plan	$287,000	5,744
Geographic Managed Care	$55,000	1,101
PHP	$1,000	4
PACE	$1,000	26
SCAN	$3,000	54
Health Net Dental	$16,000	326
Total	**$823,000**	**16,454**

PE FOR HFP DISENROLLEES

REGULAR POLICY CHANGE NUMBER:	152
IMPLEMENTATION DATE:	7/2007
ANALYST:	Stella Bertrand
FISCAL REFERENCE NUMBER:	1198

	FY 2006-07	FY 2007-08
FULL YEAR COST - TOTAL FUNDS	$0	$4,427,000
- STATE FUNDS	$0	$2,213,500
PAYMENT LAG	1.0000	0.6303
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$2,790,300
STATE FUNDS	$0	$1,395,170
FEDERAL FUNDS	$0	$1,395,170

DESCRIPTION

Under a Health Insurance Flexibility and Accountability (HIFA) Waiver, the Healthy Families Program (HFP) to Medi-Cal Bridge provides children with two additional months of HFP coverage when HFP has determined that a child's household income is below HFP eligibility requirements at the annual eligibility review. Approximately 2,000 new children currently become eligible for the Bridge each month.

The HFP to Medi-Cal Bridge will be replaced by Medi-Cal presumptive eligibility (PE) due to the expiration of the HIFA waiver. Once HFP coverage is discontinued, presumptive eligibility for Medi-Cal will be provided by submitting a Medi-Cal application for the child to the Single Point of Entry (SPE). Medi-Cal Accelerated Enrollment will then be established for the child. Medi-Cal already has authority for the SPE to grant PE in its State Plan, and current processes are already in place to transfer case information to the 58 counties for final determination.

There will be savings reflected in the MRMIB Budget for no longer providing the HFP to Medi-Cal Bridge coverage.

Assumptions:

1. It is assumed that Medi-Cal PE for HFP disenrollees will be implemented on July 1, 2007.

2. Based on MRMIB's HFP Two-Month Bridge data, the average number of new Bridge eligibles per month is 2,062 in FY 2007-08. It is assumed that these children would be placed in PE for Medi-Cal.

3. Based on 2005 data on Accelerated Enrollment (AE) eligibles (aid code 8E), assume 17% of HFP to Medi-Cal Bridge children will be eligible for one month, 27% for two months, and 56% for an average of 8 months.

One-Month Coverage	2,062 X 17%	=	351
Two-Month Coverage	2,062 X 27%	=	557
Eight-Month Coverage	2,062 X 56%	=	1,154

PE FOR HFP DISENROLLEES

REGULAR POLICY CHANGE NUMBER: 152

4. The Medi-Cal PE costs are assumed to be 1 month for the 351, and 2 months for the 557 and the 1,154.

5. Based on 2005 data, assume that there will be an additional 6 months of PE for those that will have more than 2 months of PE eligibility and who do not enroll in ongoing Medi-Cal.

6. It is assumed that the number of children approved for ongoing Medi-Cal is the same as the percentage of 8E children that become ongoing Medi-Cal eligibles after having more than 2 months of 8E eligibility, 18.5%. There are no new costs for additional months of PE for the percent that currently become ongoing MC eligibles. There are new costs for the 81.5% that are assumed to be discontinued after PE.

Discontinued after PE	1,154 X 81.5% =	941

7. The 8E cost per eligible is $39.17, based on the 8E expenditure data for FY 2005-06 and 8E MEDS data from April 2005 through March 2006 plus dental costs of $8.51. Assume this will be the cost under Medi-Cal PE as they will no longer have coverage under a health plan, will have had their medical needs met prior to PE and will have to find a fee-for-service provider for any needed care.

8. The total benefit costs for FY 2007-08 are as follows:

351 x 1 mo. coverage x 12 mos. x $39.17	=	$165,000 ($82,500 GF)
1,711 (557 + 1,154) x 2 mos. coverage x 12 mos. x $39.17	=	$1,608,000 ($804,000 GF)
941 x 6 mos. addtnl. coverage x 12 mos. x $39.17	=	$2,654,000 ($1,327,000 GF)
Total Costs	**=**	**$4,427,000 ($2,213,500 GF)**

COVERAGE FOR FORMER AGNEWS RESIDENTS

REGULAR POLICY CHANGE NUMBER:	153
IMPLEMENTATION DATE:	7/2007
ANALYST:	Michelle Santiago
FISCAL REFERENCE NUMBER:	1199

	FY 2006-07	FY 2007-08
FULL YEAR COST - TOTAL FUNDS	$0	$3,758,000
- STATE FUNDS	$0	$1,879,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$3,758,000
STATE FUNDS	$0	$1,879,000
FEDERAL FUNDS	$0	$1,879,000

DESCRIPTION

The California Department of Developmental Services (CDDS) submitted a plan to the Legislature in January 2005 to close the Agnews Developmental Center. The closure plan was approved and the projected closure date is June 30, 2008. Approximately 250 Agnews clients have moved or will move into communities, of which 184 are expected to be placed in Alameda, San Mateo, and Santa Clara counties.

Agnews clients moving to San Mateo County will automatically be enrolled in the county organized system, Health Plan of San Mateo. Agnews clients moving to Alameda and Santa Clara counties will have the option of enrolling in Medi-Cal managed care or remaining in fee-for-service. It is expected that most will enroll in managed care. Due to the significant behavioral, health, and personal care needs of these clients, current capitation rates will not provide sufficient funding to meet Agnews clients' needs. The Department intends to establish a mechanism whereby the plans will be paid an enhanced interim capitation rate for these individuals, followed by periodic supplemental payments to fully reimburse the plans for all appropriate costs.

Assumptions:

1. Agnews residents began moving into the community in July 2006.
2. Based on assumptions from CDDS, 88 Agnews clients will relocate within Alameda, San Mateo, and Santa Clara Counties on a staggered basis, from May 2007 through June 2008. It is assumed that the residents moving after May 1, 2007 are the ones for which additional managed care funding will be necessary.
3. Assume that the increased costs to managed care will begin in July 2007.
4. Assume that individuals will be phased-in to managed care over 12 months, resulting in a total of 764 member months for FY 2007-08.

COVERAGE FOR FORMER AGNEWS RESIDENTS

REGULAR POLICY CHANGE NUMBER: 153

5. Assume an average monthly cost per member of $4,919. Average monthly costs are based on actual Agnews Developmental Center physician and ancillary healthcare expenditures for FY 2004-05, adjusted for inflation, as reported by CDDS.

6. Costs for FY 2007-08 are calculated by multiplying the total member months by the average cost per member:

   FY 2007-08: 764 x $4,919 = **$3,758,000** Total Funds